COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Reference: Nursing inquiry

FRIDAY, 15 MARCH 2002

HOBART

BY AUTHORITY OF THE SENATE

SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Friday, 15 March 2002

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

Participating members: Senators Abetz, Bartlett, Bishop, Calvert, Carr, Chapman, Coonan, Crane, Crossin, Denman, Eggleston, Evans, Faulkner, Ferguson, Ferris, Forshaw, Harradine, Lightfoot, Mason, McGauran, Furphy, Payne, Tierney, Watson and West

Senators in attendance: Senators Crowley and Tchen

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.

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Committee met at 10.20 a.m.

ELLIS, Mrs Neroli May, Branch Secretary, Tasmanian Branch, Australian Nursing Federation

BURKE, Ms Susanne Mary, Member, Tasmanian No. 1 Branch, Health Services Union of Australia

KLEYN, Mr Thomas, Industrial Officer, Tasmanian No. 1 Branch, Health Services Union of Australia

CHAIR—I declare open this further hearing of the Community Affairs References Committee's inquiry into nursing. I welcome you and thank all the people who have assisted us with the late rearrangement of the starting time for this hearing. The committee prefers all evidence to be heard in public, but should you wish to give evidence or 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. The committee has before it your submissions Nos 773 and 754. Do you wish to make any alterations to those submissions?

Mr Kleyn—No, Senator. I would like to make some additional points if that is permissible.

CHAIR—Yes. I invite you to make some opening statements. We will then have questions. I do not know how you have worked out who is going first.

Mrs Ellis—Thank you, Senator. I will start off. I would like to add a few issues that have arisen since our regional submission was made in June 2001. I would like to address the submission for five to 10 minutes. The Australian Nursing Federation has over 130,000 members throughout Australia. We surveyed our Tasmanian membership in June 2001 to obtain feedback for this inquiry. The submission was made by my predecessor. The responses were from nurses in the private sector, the acute sector, community health, mental health, and remote and rural regions, so they covered the whole sectors of the Tasmanian nursing community.

Tasmania is being affected by a shortage of nurses which is obviously affecting our recruitment and retention in this state. The issue will not diminish until we actually address the current staffing levels and the workplace conditions that are currently here. We have an ageing population in Tasmania and the average age of nurses is 44 years. We have a recent planning report delivered in February 2002 that shows some alarming statistics for nurses in Tasmania. Against the national trend, Tasmania has a decreasing registration of nurses. Since 1993 we have had a decline in registration of nurses in Tasmania of 22.5 per cent. Also, we are the only state that has a decrease in full-time equivalent nursing staff per bed in the public system. That is also against the national trend.

The reasons for the nursing shortage are workplace issues resulting from decreasing funding to the public hospital system. This has impacted on the nursing board and staffing levels. The second issue is the lack of a national work force strategy. The national research on requirements for future nursing positions is needed both for the undergraduate and postgraduate needs assessment. We also would suggest the chief nurse position be re-established throughout Australia for the direction and guidance of nursing in the future.

I would like to just recap on our submission. We actually asked the five questions relating to the terms of reference. We asked nurses to briefly describe their current work situation and the factors impacting on their working lives. The 200 responses that we received indicated that workloads were a major factor impacting on their working lives. We did not get one response where that was not an indication of the major factor in relation to their working lives.

There is also a continuous expectation for nurses to miss meal breaks and work unclaimed overtime. They are unable to attend professional development. The expectation for nurses to work double shifts on a weekly basis throughout the public sector in Tasmania—and certainly the expectation for part-timers to be available to work extra shifts on an ongoing basis—is exhausting the community of nursing in Tasmania. Constantly, nurses are working short. We are unable to replace those on sick leave and unable to find nurses to provide relief cover.

We also have some issues with skill mix, particularly in aged care. One comment was that there was one registered nurse to 96 residents. Under the Nursing Act, obviously that registered nurse is going to be accountable for all that care delivered during their shift. That is putting incredible stress on the registered nurses working in the aged care sector.

The shift work is also impacting on our older nurses in Tasmania. With the average age of 44, obviously they are not exempt from night duty and the requirements of shift work, so that is having some adverse effects. In Tasmania, unlike the other states, we have no acuity system, no patient dependency tool, where we can actually objectively measure the nursing hours required for our patients and utilise that as evidence based to demand extra nursing hours as the acuity of the patient obviously dictates. So without that objective tool or acuity system, it is very difficult to justify by other clinical needs. Obviously at the moment the nurses are actually stating on clinical needs the reasons that we need extra nurses and extra staff. We do not have those figures to put through to those that are making the financial decisions, and that is obviously causing some problems without the acuity system.

Other issues relating to the factors in our working lives include excessive documentation, particularly in aged care. I was really alarmed this week. I visited an accident emergency ward in one of the major public hospitals here, and they were talking about the increasing violence against nurses. There is an inability for nurses to even document those incidents because they do not have time. I am really alarmed about the factors that are impacting on their lives and it is an occupational health and safety issue as well. In Tasmania we have a workplace health and safety act, which does put a duty of care on to the employer to provide a safe working environment, and that includes staffing. We are really concerned that a safe working environment is not been provided, despite the duty of care on the employer to provide that scenario.

On a regular basis, ANF is attending unit based meetings ward by ward, hospital by hospital, in the private sector and the public sector and in aged care. We are looking at the potential breach of duty of care and the associated risks. The nurses are only coming in and calling for those ward meetings when they are absolutely at the brink, and they are stating the issues relating to that. They are recognising it is an enormous potential breach of duty of care, and that is the level we are getting to in Tasmania at the moment.

Certainly we have some issues in the remote areas. Tasmania seems fairly small, but we do have remote areas hidden behind those mountains, particularly in areas like Queenstown, where the midwives are actually required to work their shifts as well as be on call in between shifts. They are called out on a constant basis. They are also required to man the ambulance service in those particular regions. So on top of their normal shifts, plus being on call as nurses and midwives, they are than expected to go out to triage and to ambulance the mining accidents et cetera around the west coast. So they are particular problems in those remote areas. The fact is that we do not have people wanting to relieve them for their annual leave et cetera, so there are some that are having difficulties being released in those areas as well. So there are some factors in the remote areas of Tasmania.

There are some strategies that nurses have come up with in looking at how we can assist with recruitment and retention. The responses from all nurses showed that, until we actually address workload issues in the current environment, we will have trouble retaining nurses let alone trying to recruit them. So we really need to address the nursing workload at the moment. The nurses came up with various ideas, including child-care initiatives, such as subsidising child care. There are also other incentives. We need support for our postgraduates. With the number of clinical placements coming into the sector now, we are expecting our current workload to actually precept those nurses coming in. We also have foreign students, new graduates, re-entry and new enrolled nurse trainees coming in. They are all needing to be precepted by the current work force. They are not bringing in with them clinical educators to actually precept, mentor and support them. The current nurses—and most of those are senior nurses—are in charge of the ward, plus a patient load, and they are actually mentoring and precepting those new learners into that environment. That is causing incredible stress on those who are already being stressed in the workplace at the moment.

We also have a problem in Tasmania with temporary contracts and the lack of permanency in employment. We have about 25 per cent of nurses on temporary contracts, which is against public sector ratios. There is an increasing amount of frustration with the fact that nurses cannot get permanency in the public sector and with the fact that they are on constant fixed term contracts.

There is inflexibility in shift work. We need a review of our career structure. The nurse practitioner model is not in Tasmania yet and we are looking forward to implementing that career structure. There are some issues with national nomenclature and with the confusion around the country with different names of nurses—division 2 nurses, enrolled nurses, division 1 nurses in Victoria are registered nurses and the level 3 nurses around the country are doing different roles and paid and structured at different levels. There is huge confusion when we look at interstate travel. We have mutual recognition of nursing through the boards but they do need to pay registration in each of the states. In Tasmania, our registration is the highest at $105 compared to $30-odd in New South Wales. So there are issues with registration as well.

Nationally, ANF is advocating for a chief nursing position to be re-established to coordinate the national nursing direction. We are also looking at fully refunded re-entry programs for midwives, registered nurses and enrolled nurses, not only including their theoretical modules but also their clinical placement so that they are actually supernumerary. The employer who is taking on those re-entry program nurses needs to be subsidised to provide the clinical preceptors

in time for the existing staff and maybe to provide additional staff to help with those re-entry programs.

The next question was: what changes do you think would assist the interface between universities and the health system and better prepare nurses to meet future labour force needs? Certainly, we need Commonwealth funding for increased nursing positions in the university. We had the highest rate of increase of applications this year for nursing. There is a demand for people wanting to do nursing, particularly the enrolled certificate IV courses. We have got a huge demand for that course as well. There seems to be no national strategy looking at that work force research to look at future needs and demands. We would suggest that that would be a recommendation in relation to looking at national curriculums with the mutual recognition act. Enrolled nurses have totally different curriculums in different states, yet they can be registered in their state. But when you come to national recognition, every state recognises the fact that they are registered and enrolled as nurses as opposed to the actual curriculum that they have been involved in.

We also have some problems here, potential future problems with our specialised postgraduate nurses. We need to look at the shortages in those specific areas and look at postgraduate exemption from fees. At the moment, it is costing $10,000 for nurses to do the postgraduate course and that is obviously more than just the cost of the fees.

In relation to further interface issues and support of clinical placement, I have said that students are not to be counted as staffing numbers. More often than not, students coming into the wards are being counted as part of the staffing numbers for the patient care for that shift, due to nursing shortages. That is not giving them support. It is not helping with retention for when they do graduate and come back into the system. It is fairly wild out there for the postgraduate year as well when they do not get enough support from those nurses who are in the work force.

We did a survey and looked at how many years people had been in nursing. It reflects the demographics of the reports that we have had. Seventy-five per cent of the nurses who responded have been nursing greater than 11 years. The majority of those have been in nursing greater than 20 years. Probably the most alarming question that we asked was for them to estimate the number of years they could expect to remain in nursing. Of all responses, we only had one positive response. You are probably chuckling because you have read the responses. It is quite clear that people are looking to get out as quickly as possible and that is very distressing for us. In summary, the major reason is decreased funding to the public hospital system, which has impacted on a decrease in staffing positions.

CHAIR—I would hate to be misunderstood about why I was chuckling. I think that sometimes when hearing evidence a question should never have been asked. When people were asked how many years they expected to remain in nursing and only one person said they would like to stay, it is a pretty significant piece of information.

Mrs Ellis—It certainly is alarming.

CHAIR—I ask the Health Services Union to make their contribution now and then we will have questions.

Mr Kleyn—Senators, I would like to make a few points, particularly concerning some comparable pay rates between registered nurses, or nurses in general, and other health professionals. In Tasmania, nurses are paid considerably less than their counterparts in other health professions—for example, physiotherapy, occupational therapy and podiatry. If you look at the comparison of pay rates, a level 1 registered nurse with eight years of service is currently paid $43,737, while a health professional level 1 with eight years of service receives $47,375—an eight per cent gap between the two rates of pay. Similarly, level 2 nurses receive $48,480 at the top of the range, whereas a level 2 health professional receives $53,939, which is a difference of 11 per cent.

The comparison of pay rates in the aged care sector is even worse. A registered nurse level 1 with eight years of service in the aged care sector receives $40,126. That is about nine per cent less than a registered nurse similarly qualified in an acute care setting and up to 18 per cent less than a comparable health professional. Certainly, the question must be asked: why would you become a nurse? Health professionals generally do not have to work shiftwork. They do not have the same levels of stress and pressure as nurses. If you had the option of choosing occupational therapy, physiotherapy or nursing, given the disparity in pay rates, then I believe that most people would choose some of the other professions.

CHAIR—What do you mean by level 1? We are not actually talking about an enrolled nurse or an RN; we are talking about an RN with eight years experience?

Mr Kleyn—A registered nurse with eight years experience, classified as level 1.

CHAIR—Does eight years get you to level 1?

Mr Kleyn—You can stay at level 1 for eight years.

CHAIR—And after that you would go—

Mr Kleyn—After that you can apply for promotable positions at level 2 and above.

CHAIR—Can you get through to level 2 in a shorter time than eight years?

Mr Kleyn—Yes. If you apply for a level 2 position after one year, you could move straight to level 2, but that same situation applies to health professionals.

CHAIR—The comparison is—

Mr Kleyn—The career structure is very similar for nurses. If you look at each level within the structure, the disparity in pay gets worse the higher you go.

CHAIR—What does an EN—an enrolled nurse—in Tasmania start on?

Mr Kleyn—I do not have those rates with me.

CHAIR—That is okay, we will come back to them later.

Mr Kleyn—I can provide those.

CHAIR—Could Mrs Ellis give them to us later?

Mrs Ellis—Yes, I have got them. Could I clarify that there are seven increments for the level 1 position, so many senior nurses actually commence as level 1, year two, and then have increments and rise to level 1, year eight. At year eight, that is where you actually stop unless you apply for further promotion and are successful.

CHAIR—If you graduate and start working as a nurse, you are an RN. Level 1 means that you have got the potential to be eight years gradually incrementing?

Mrs Ellis—Yes. You come in as level 1, year two in Tasmania, with the accelerated advancement of our award, after the tertiary—

CHAIR—I do not think I need to ask any further questions about this. Level 1, year two.

Mrs Ellis—That is where you begin.

CHAIR—But after a while—and that can be whenever you apply and you may be successful—you can get to level 2 in less than eight years?

Mr Kleyn—Yes, but you could stay as a level 1 nurse for eight years or for your entire career, because getting to higher classification positions requires you to be available and for you to apply for them. There is no automatic advancement from one level to another.

CHAIR—When you are in level 2, is it the same? Is it an eight-year increment or is it six years?

Mrs Ellis—No, it is four years for level 2.

CHAIR—Four years, with increments creeping up. And then you would go to what level?

Mr Kleyn—Level 3.

CHAIR—What is that salary?

Mr Kleyn—I do not have that; we could provide that.

CHAIR—If you are a level 3, are you actually what we used to call—people as old as me—matrons?

Mrs Ellis—Charge nurse.

CHAIR—Not a DON?

Mrs Ellis—No.

CHAIR—What do you have to do to be a DON?

Mrs Ellis—Level 5 is a DON. Level 4 is an assistant director. I have got the schedule here.

CHAIR—If you could send us a piece of paper that says year one, level 2, it would be a very big help. It would take us from the beginning to the end. Just mark the hurdles with a red line—this is where you have to apply to be considered to go to level 2 et cetera.

Mr Kleyn—If you like, I will give you the same documents for the health professional structure as well so that you can look at the comparisons.

CHAIR—That would be great, and if you could pop in the EN structure as well, that would be very helpful for the committee.

Mr Kleyn—Yes.

CHAIR—Thank you.

Ms Burke—But nurses may spend their entire career working as a level 1 nurse.

CHAIR—That is very important for us to know. Thank you, Ms Burke.

Mr Kleyn—Neroli has made a number of comments about working conditions. I would also like to make a few comments about aged care, in that we conducted a survey of our nurses in aged care. Of the responses that we got, 60 per cent of the respondents reported that the level of documentation in aged care has had a negative impact on patient care since the changes to aged care funding in the mid-1990s. Ninety per cent reported spending a minimum of two hours per shift on documentation and paperwork, thus decreasing the time spent on patient care. One hundred per cent reported an increase in workload and 84 per cent reported that they worked unpaid overtime. In aged care, there has been a decrease in the number of nurses employed, certainly in the non-government, not-for-profit sector which dominates the Tasmanian nursing home industry. There was a decline of 26.4 per cent in the number of nurses employed.

CHAIR—From what to what? What were the actual numbers? Was it 26 per cent starting—

Mr Kleyn—I do not know the actual numbers; I can provide those to you.

CHAIR—Thank you.

Mr Kleyn—In aged care, in particular—but it is occurring across all health sectors—there is an increasing trend to employ personal carers rather than enrolled nurses or registered nurses. This is particularly the case in aged care and also in some of the community settings like disability services where nurses are very thin on the ground.

CHAIR—Is a personal carer sometimes called a level 3 nurse?

Mr Kleyn—No.

Mrs Ellis—They have a certificate III. In other states they are sometimes called assistants in nursing.

Ms Burke—Many of the people who are working as personal carers here in Hobart in the aged care setting are people who have had only four or six weeks training prior to going to bedside.

CHAIR—Is that TAFE training?

Mr Kleyn—It is registered training organisation training. It is not necessarily TAFE; it may be through a registered training organisation—for example, Northern Group Training.

CHAIR—It is non-university?

Mr Kleyn—Yes, it is non-university.

Mrs Ellis—The certificate III in aged care is actually done through TAFE—it is a 12-month course.

Mr Kleyn—We believe the federal government certainly has a role in alleviating the critical nurse shortage. We believe that there should be increased funding to public health services and to aged care services. One of the issues in aged care for us as a union has been the inability to enter into enterprise bargaining arrangements with the nursing home industry on the basis that there are no funds for wage increases. For the first time in many years, we have negotiated and finalised an enterprise bargaining agreement for nurses across the nursing home industry but, as yet, we have not been able to achieve that for non-nurses. The wage comparisons between aged care and acute care nurses and aged care and health professionals, which I cited earlier, are after a 10 per cent increase in the nurse wage rates in aged care.

The aged care sector in particular is feeling the pinch in terms of a shortage of nurses. That is exacerbated in the more rural and remote areas. I do not have any evidence to back this up, but a newspaper report indicated that the University of Tasmania had a higher number of applications for enrolment into a nursing undergraduate degree course this year but, because of the lack of funding and the lack of places, they could not offer them. We also think the federal government should examine HECS arrangements for nurses and investigate options of providing a temporary moratorium on HECS fees for undergraduate courses as well as for postgraduate courses. That is all that I would like to say at the moment.

CHAIR—Thank you very much. Can I just be clear on this: the Health Services Union represents 8,000 members working in all areas of the health industry, and 25 per cent of those are registered and enrolled nurses. Do you mainly cover people outside public hospitals?

Mr Kleyn—We cover people in public hospitals, private hospitals, nursing homes, community services and disability services. We cover the entire health and community services sectors.

CHAIR—How do you get on with your colleagues from the ANF?

Mr Kleyn—Reasonably.

CHAIR—I have been asking questions about nursing and nursing union coverage for a long time, so I am very pleased with that answer, Mr Kleyn.

Mr Kleyn—So you are aware of the history of it all?

CHAIR—I am indeed. Do both of you actually cover nurses in a public hospital?

Mr Kleyn—Yes, we do.

CHAIR—And how do you draw the line there? Is it an option for the nurses or is it areas that you are talking about?

Mr Kleyn—No. It is an option for the nurses. We do not demark in any particular area. Nurses, wherever they work in the state of Tasmania, have an option of joining either us or the ANF.

CHAIR—If somebody worked in aged care and joined your union, are they likely to stay with you when they move into a public hospital, for example?

Mr Kleyn—Yes.

CHAIR—Are there many nurses moving from one union to another?

Mrs Ellis—Yes, we do have some movements. We represent purely nurses. As you are aware, the eligibility for the Australian Nursing Federation is that you have to be an enrolled nurse or a registered nurse, but we obviously realise that for the benefit of nurses we need to work cooperatively.

CHAIR—Old union demarcation wars were probably not constructive.

Mr Kleyn—In aged care we cover the personal carers as well as the nurses. We cover the entire work force really.

CHAIR—That is very helpful.

Mrs Ellis—Just to clarify that, the Australian Nursing Federation in most other states actually do cover personal carers and assistants in nursing. Tasmania, the ACT, the Northern Territory and South Australia have an eligibility rule change at the moment, so it is slightly different in other states, where they do cover personal carers and assistants in nursing.

CHAIR—We have heard that the wages paid at various parts of the mainland suggest there is not too much difference in salary, but I am concerned to read in a number of submissions that many nurses who train in Tasmania then go to work on the mainland because there is an increase in salary. Do you have any wage comparisons? If not, we will seek them from other

places. You are both nodding in agreement that the wage differential is one inducement for nurses who train here to go and work on the mainland.

Mr Kleyn—Yes.

Mrs Ellis—It is not only the wages; it is actually the conditions. Certainly the conditions in Victoria are incredibly attractive to Tasmanian nurses at the moment. With a regulated nurse-patient ratio, they know that they can come on to the shift with a safe workload and safe staffing levels. In their enterprise agreement they do have paid professional leave and time is allocated for that. We do not have that in Tasmania. It is very difficult to access professional development time in Tasmania. It is at management's discretion and, with the incredible staffing difficulties that we have at the moment, the discretion is more often than not that they cannot attend professional development.

CHAIR—What is your best understanding—or can you give the committee any figures—on the amount of shortage? What is the nursing shortage in Tasmania?

Mrs Ellis—We have actually put a proposal forward along the lines of the nursing hours per patient day. We are forwarding that to the department next week. Certainly that would look at an increase of staff—and we are just costing that at the moment—an extra nurse per shift, per ward for the early and late shifts. We are utilising that model which is based on the recent decision from WA and using the categories and guidelines that the decision actually made as an order.

CHAIR—How many nurses do you estimate would be on a shift? Have you got 100 nurses and you need another 10? Do you have any solid figures of how big the shortage of nurses is in Tasmania?

Mrs Ellis—No. We are actually currently costing it. As soon as I get those figures, I am happy to forward them to you.

CHAIR—What do you mean you are costing it?

Mrs Ellis—We are actually doing an analysis at the moment of what we are actually going to require as per our model that we are putting forward, so we will know exactly the extra FTEs that are required to staff this model and the costs involved.

CHAIR—If that were available in the next month or so, that would be very useful for us.

Mrs Ellis—Yes, it probably will be.

CHAIR—Thank you very much. Can I ask too, just before I call Senator Tchen: do you use agency nurses in Tasmania?

Mrs Ellis—Agencies have only just started in Tasmania in the last few years. The public sector were very loath to use agencies in the past and had their own banks or pools within the public sector, as did the private sector. The hospitals had their own casual staff that they utilised.

We have had one agency in the south and one agency in the north—and one agency in the north-west that has just started too—and they do—

CHAIR—What are they charging?

Mrs Ellis—They do charge reasonable rates. They are nothing compared to the Victorian rates. It is the award rate plus 20 to 30 per cent commission for the agency.

CHAIR—How much a week is a nurse getting?

Mrs Ellis—The nurse is getting the hourly rate of about $22.

CHAIR—Plus 20 per cent goes to the agency?

Mrs Ellis—That is right.

CHAIR—That certainly is terribly different from the agency figures in Victoria—

Mrs Ellis—Absolutely.

CHAIR—where, we were told from Western Australia, they were charging on average $200 to $260 per hour.

Mrs Ellis—Yes, in Victoria market rates are $150 an hour for agency nurses.

CHAIR—And the agency was taking 55 per cent of that figure. You will be pleased to know, as I am sure you do, that the Victorian government has put the kybosh on that a couple of weeks ago and now no agency nurses are being employed by the public hospitals. That is going to cause some difficulty in terms of wards closing in the short term, but it will save the government $20 million. That is not the situation in Tasmania?

Mrs Ellis—No, it is not at all.

CHAIR—How many nurses are coming through the agencies? Do you have any figures on that?

Mrs Ellis—The hospitals do have their own casual pools. The preference is obviously to call in their own part-time staff because they do not attract the 20 per cent loading. They try and call in their part timers first, then they relate to their own casual staff and, when they are desperate, they start going to the agencies. Certainly, it is more in the Royal Hobart Hospital, but in the north they probably only use about 10 per cent casual staff.

CHAIR—What on earth would be the benefit of an agency if the nurses are going to get the same amount of money and if the hospitals and the employers have large pools?

Mrs Ellis—The agencies are probably staffing more the remote areas, the private sector, not the public system as much.

Mr Kleyn—It is possible to have a situation where you have a nurse working part time for a public hospital and also part time for the agency. You have scenarios like that.

Senator TCHEN—In the last few moments, I have been hearing something which I do not quite understand. It sounds a little bit strange that, in Tasmania, you seem to have a nursing shortage which is apparently more acute than on the north island, yet you are in a less strong bargaining position in terms of improving your working conditions and pay standard. How can that be? If you have a short supply of a service or a good, according to classical economic theory you should be in a stronger bargaining position.

Mr Kleyn—Yes, but the employer that you negotiate with has to have the capacity to pay. We might be in a strong bargaining position in some areas but the government has got to find the funding to pay for the increased rates. If you look at it historically, the outcomes of the nursing enterprise bargaining agreements have been at a higher level than the general trend in enterprise bargaining increases in Tasmania, but it still has not alleviated the problem. The point I made earlier about the comparison with health professionals is that, if you had a choice of choosing a career in nursing or in physiotherapy, the pay rates and conditions of work are significantly better. That is a significant factor. Public hospitals in particular and aged care facilities do not have the kind of capacity to deliver high wage outcomes.

Senator TCHEN—This question of parity of pay between occupations will be an important issue. It is a real minefield, and I hesitate to enter it without talking to other occupations as well. Certainly, that is something we probably need to look into. I am not sure that it is in our terms of reference this time.

Mr Kleyn—I would say it fits into point 3.

Senator TCHEN—You have made a number of statements, Mr Kleyn. If you have information about the lack of parity you are talking about, we would appreciate it if you could supply that information to us. Also, on that point, Mrs Ellis, thank you for letting us know about the survey you conducted. Have you made that data from the survey available to us?

Mrs Ellis—I believe you have that data. That was part of our submission.

Senator TCHEN—I thought you made the submission before you came back with the survey?

Mrs Ellis—No. The submission was based on the survey results.

Senator TCHEN—Thank you.

Mrs Ellis—Can I make a comment in relation to the industrial position that you are stating in regard to the market demands et cetera?

Senator TCHEN—Yes.

Mrs Ellis—Tasmanian nurses did vote on an enterprise agreement last year. It was certified. Quite a few of the clauses were quite open to implementation and were not finalised. Certainly we are having some issues now with the postgraduate allowance that was voted on in good faith by the nurses. The department has put a new position now just accepting the tertiary postgraduate qualifications and not accepting those that have been hospital trained and then gone on to gain their hospital certification in midwifery, intensive care and other specialised areas. Eighty per cent of the nurses in Tasmania have actually gained their further qualifications through the hospital system because we have only had the postgraduate availability of those courses in Tasmania for the last six years. The average age is 44, so the majority of nurses have gained specialised qualifications through the hospital system and are accredited and endorsed through the nursing board and meet the same competency standards as the postgraduate nurses do in those specialised areas. So we have got some rumblings, and I can certainly assure you that nurses are not complacent in Tasmania. They are quite angry at the moment about the situation that they are in compared to their colleagues on the mainland, who are enjoying the benefits of postgraduate allowance and benefits, as I said, far in excess of Tasmanian nurses.

Senator TCHEN—Senator Crowley has already touched on this point, but I just ask you again: in your assessment, how much of Tasmania's shortage of nurses could be attributed to qualified nurses moving to the mainland for better employment opportunities?

Mr Kleyn—That would have to be looked at in the context of Tasmania's population shift. It is very hard to look at it in terms of just nurses, but there is a general movement of young people and young graduates across a range of professions from Tasmania to the mainland. There are a number of reasons. The wages and conditions are better, and you would also have to look at lifestyle reasons as well. It is very hard to isolate nurses and say that this is the reason that nurses go. The same thing occurs amongst a whole range of health professionals. Often in most of the health professions they do not train here. They train on the mainland, they come to get experience in Tasmania and then they go.

Mrs Ellis—I tend to probably disagree a little bit on that. I believe that nurses do tend to trend to the mainland for experience, for conditions and for all sorts of reasons in the bigger hospitals. Certainly for the conditions and pay I am hearing those results. It has only been the last two years that the department has actually funded postgraduate positions for all graduates that want to stay in Tasmania. We cannot fill our postgraduate positions now, and we have vacancies throughout the state because our postgraduates are leaving the state. We do not have the actual figures of exactly how many remain in Tasmania and how many leave, but certainly anecdotally it seems that a large proportion do leave the state. We are not attracting them to stay in Tasmania.

CHAIR—Do people migrate to Tasmania?

Mrs Ellis—Speaking for ANF and our membership, we monitor those that transfer from interstate branches down to Tasmania. If we lose 10 in a month to the mainland, we get two in per month. Those are the figures at the moment.

CHAIR—Just tell me that again. If you lose—

Mrs Ellis—We are tending to lose about 10 members transferring to ANF branches in other states at the moment.

CHAIR—And getting two back?

Mrs Ellis—Potentially we get one or two back each month.

CHAIR—Senator Tchen, do you mind if I pursue this for a bit?

Senator TCHEN—No.

CHAIR—Are you advertising for overseas nurses?

Mrs Ellis—Yes. We are advertising in all of our Australian nursing journals. There is certainly a marketing strategy being looked at on the web sites. There are recruitment sites there looking at attracting nurses. But there is such an inflexibility in the public sector as far as the employment of nurses is concerned. We cannot offer above award conditions. As an example, King Island was trying to recruit recently for a nurse. It is a very small island in the Bass Strait. Because they did have an incentive of two return airfares from wherever you lived, they got 15 applications, which is absolutely unheard of for a nursing position in Tasmania at the moment. Most positions receive one—if even one—application.

CHAIR—It is all the cheese. Where did they come from?

Mrs Ellis—The mainland.

CHAIR—From overseas. Sometimes Tasmania tells me that the mainland is overseas. I have always regarded you as part of Australia. When I said overseas, I did mean the Philippines, Canada or wherever.

Mrs Ellis—No, I was talking about Australia.

CHAIR—I was teasing there, Mrs Ellis. How many nurses are there from overseas?

Mrs Ellis—I would say it would be a very small proportion of nurses from overseas coming in to Tasmania.

Senator TCHEN—One of our new Tasmanian colleagues actually described to me that it is not the mainland, it is the north island.

Ms Burke—I am a nurse of 40 years and I had a step-out to have three daughters. I look at their choice of careers. One went into nursing and two went into commerce. The one who went into nursing stepped out after her first 12 months. Part of it was the fact that in the university culture they are doing some of the comparisons about pay, conditions and future career paths. Many will start nursing and will switch.

I think the second point about the graduates moving before they are actually at the end of their university career has something to do with the fact that they have been living a campus life, as some of the allied professionals have. Physios have always been in universities. They came from part of nursing and broke off into their specialties and historically have been in universities all along, whereas nurses were training in hospitals scattered throughout the island. Over their training time they established friendships. Sometimes they met local people. So they had an established network in the community and so they stayed on staff. Amongst other things, that also contains some of the reasons why on this small island we are not getting people to remain. They finish their degree. There are weekly ads for nurses in our local newspapers for throughout Australia but also to the Middle East, the United States and the UK. The world is my oyster when I am 21 or 22 and I am off.

CHAIR—And we do not know when they come back.

Ms Burke—Many of them do not come back. If they do come back to Australia it is not to Tasmania.

CHAIR—Tasmania has a declining population.

Ms Burke—Yes, very much in that age group. We have the littlies, the elderly and a dearth in the middle.

Senator TCHEN—Mr Kleyn, there are two other points you raised in your oral submission that I would like to clarify. Firstly, you said you understand that the University of Tasmania nursing course had more applicants than they had places and they were not able to meet all the demands. Do you know whether any of the applications were actually from the mainland?

Mr Kleyn—No, I do not. As I said earlier, I do not have any hard evidence to back it up. I assume I could get it. It was a newspaper report which indicated that the University of Tasmania had a record number of applications to undertake nurse undergraduate degrees.

Mrs Ellis—I can respond to that. There were some applications from the mainland and there were an extra 15 funded positions that were granted to the School of Nursing this year. Yet there were still not enough places.

Senator TCHEN—And the tertiary students are very footloose as well. They are very selective as well. The other issue that you raised, Mr Kleyn, is the concern with overdocumentation, particularly in the aged care area. You say there is, on average, two hours per shift being spent on that. Is that a recent phenomenon or is it a response to some of the public concern about the aged care area?

Mr Kleyn—The indications we have from our nurse members is that it is a relatively recent phenomenon. It stems largely from the present government’s changes to aged care funding. The documentation has increased dramatically. The other point is also that under previous arrangements nursing homes were actually required and funded for nursing positions. That has changed as well.

Senator TCHEN—So the documentation becomes a responsibility of the enrolled nurse?

Mr Kleyn—Or the registered nurse. And the number of nurses in aged care has declined considerably. As there is no longer a requirement for them to employ registered nurses, there are fewer registered nurses employed and the fewer there are, the more paperwork is left.

Senator TCHEN—In your comment, you have some concern about using untrained health care workers. I would like you to expand on that, particularly because, later on, we have a witness who is proposing stratas in the nursing occupation, with the people who are less trained doing the personal care areas. Can you comment on that?

Mr Kleyn—One of the concerns that we have in particular is the administration of medication. I understand there is a report—and I do not know whether or not it has been handed to federal government as yet—into the regulation of administration of medication. It is my understanding that the report will recommend that, once the medication has been prescribed by a pharmacist or a doctor, anybody will be able to administer it. We are seeing this increasingly occur in the community sector, particularly in disability services. With a number of our members in nursing homes, the personal care classified people are starting to be pressured to administer medication, which is a significant concern.

The issue is that there is greater pressure on those personal carers because there fewer nurses to take on a range of duties that have traditionally been regarded as nursing duties, particularly in direct care situations. We are coming under some pressure, and a number of our members are coming under pressure even in public hospitals, to create new types of positions which have become part of the direct care but which has never been the case before. So there are some nursing duties which have traditionally been nursing duties, but which, because of funding restrictions and because of the shortage of nursing, they are starting to try and transfer onto the personal carers. I think that trend is continuing and it is occurring right across the health sector.

Senator TCHEN—But could that be prevented by fairly strict legislative control?

Mr Kleyn—It could be, but it is not at present.

Mrs Ellis—I would like to give you an example of the legislation that is happening in Tasmania at the moment. We have got grave concerns, and we have raised those with the minister. In particular in disability areas, where we are having difficulties with the nursing shortage and in employing nurses in those areas—and there is a trend to not employ them—the draft regulations that have been forwarded are changing against national guidelines to allow disability workers with a 25-hour module of theory to administer medications. This is totally against all national standards from the APAC guidelines to medications, which state that, if direct administration of drugs is necessary they must be given by a registered or an enrolled nurse. And we have got grave concerns that we are actually lowering the standards for disabled clients purely and simply because of the nursing shortages, and we are actually changing legislation. That is our opposition.

Senator TCHEN—We heard evidence in Melbourne that there was some concern in Victoria because of the legislative restriction. Enrolled nurses are not able to administer certain medication but the personal carer can.

Mr Kleyn—That is precisely the situation here. You can have a situation where an enrolled nurse who does not have medication endorsement cannot administer medication. Somebody with less training can or does.

CHAIR—Mainly because the law does not specifically cover them?

Mr Kleyn—The Poisons Act in Tasmania is somewhat vague as to who can and cannot. We have received a legal opinion saying that non-nursing staff cannot. The department has received legal opinion saying that they can. The dilemma is at what point—

Senator TCHEN—Is the department standing on that?

Mr Kleyn—The government's view is that the Poisons Act does not preclude them from administering medication. It has never been tested in court. It has never been tested in terms of whether it is actually legal or not.

Senator TCHEN—Are you saying that the department's position is that the law does not say that they can and therefore regardless of whether or not it is dangerous they can?

Mr Kleyn—I am saying that in disability services the government's position has been that personal carers or disability support workers can administer medication because the law does not specifically state that they cannot. There are about three different legal opinions on the same matter and, needless to say, there are three different points of view.

Mrs Ellis—It is the difference between a regulated nurse who comes under the authority of the Nursing Act and the Nursing Board of Tasmania as opposed to unregulated carers or unlicensed workers—however you like to title them—who have not got the professional guidelines and coverage that regulated and registered and enrolled nurses do have under the Nursing Act.

Senator TCHEN—I have one last question for you, Mr Kleyn. Mrs Ellis might like to comment on this as well. You argue in your submission that there is scope for greater integration of hospitals in the nursing curriculum. Mrs Ellis mentioned that the downside of that practice might be that student nurses get counted into the staffing levels, which is not the intention. Perhaps you can enlarge on what your proposals are.

Mr Kleyn—This stems from the concern of graduates coming in. I will start off by saying, as we have said in our written submission, that we support the current arrangements of university based training. What we see as a problem is the difficulty in precepting those nurse undergraduates. With the nursing shortage and the pressures that experienced nurses on the job currently are facing, their having to spend time precepting graduate nurses places an even greater pressure on them. While I do not have a definitive answer on how it could be done, the point we were making was that there should be a greater integration between the Department of Health and Human Services in Tasmania and universities as to how that training is provided and how the placements are arranged.

Mrs Ellis—This could be provided through conjoined appointments. Certainly we would be encouraging clinical educators back in, funded through the university sector, to do the education

and precepting of students. As Tom said, at the moment it is reliant on those nurses already in the work force to do the assessment and precepting of the undergraduates plus the postgraduates. That would be a mechanism for improving it.

Ms Burke—I worked in Toronto. They had a system whereby nurse interns in their first year did work under a combined appointment between the university and the hospital. There were between four and six nurse undergraduates. That removed the role which at the moment we are covering. We are doing a client load, precepting and often in-charge managing. There are corners being cut and there will be problems.

Senator TCHEN—That is a graduate nurse who is more or less acting as a tutor for the undergraduates?

Ms Burke—Yes, on the job as part of her workload. What I saw in Canada was a graduate nurse in that first year being called a nurse intern and precepted as an extra position conjunct with the university or where the ongoing education came through. A lot of our nurses feel that, as undergraduates, the young and the old nurses do not welcome them. I do not think it is that at all. I think they are working under huge stress and it is just another thing that is topped on to their day with no allowance time wise for it. We are working faster, but I do not think we are working smarter. Clients are missing out. The level of care is not there. We are still dealing with frightened human psyches without that personal time.

CHAIR—You mentioned a report from last month.

Mrs Ellis—This is the *Final report of the Tasmanian nurse workforce planning project*, which purely on a Tasmanian basis looked at the work force issues.

CHAIR—Is it public? Is it available?

Mrs Ellis—It is public and I recommend it. I have not got a spare copy, unfortunately.

CHAIR—Is it available through—

Senator TCHEN—It is a government report.

CHAIR—It is a government report. Can we get it through the department?

Mrs Ellis—Yes.

CHAIR—You mention another report too. I cannot remember it. A medication report to the federal government.

Mr Kleyn—I believe it is the Galbally report. It is a report into poisons regulations throughout the country. I think the review is being conducted by Rhonda Galbally.

CHAIR—And it is currently under way?

Mr Kleyn—Yes.

CHAIR—We might chase that one down with the federal department. Thank you very much. When do nurses mainly drop out in Tasmania?

Mrs Ellis—After their first year.

CHAIR—I thought I should not say 'We have heard' but that is consistent.

Mrs Ellis—If we keep them here for the first few years, they settle into the Tasmanian community. We do not have a vast proportion of transient nurses. The ones we have here now are living here and obviously love Tasmania and staying here. When you look at the average age of the nurses they stay here for a long period and nurse for a long period.

CHAIR—Why are they dropping out in first year?

Mrs Ellis—Anecdotally, from my discussions with nurses it is the attraction from other states—the conditions, bigger hospitals, more experience.

CHAIR—We have actually heard in other places that it is because when they finally hit the wards they are gobsmacked, if I may quote a good British contributor to my wisdom.

Mr Kleyn—I think that is applicable here.

Mrs Ellis—I am not actually talking about leaving nursing altogether. I am talking about leaving Tasmania.

CHAIR—I know. I am sorry, but leaving nursing?

Mrs Ellis—Yes. They are not supported—

CHAIR—Is that the case?

Mr Kleyn—Yes. I think that is quite true.

Mrs Ellis—They are not supported in that early burning year.

CHAIR—Is it because they have not had enough clinical experience before they get onto the wards?

Mrs Ellis—In Tasmania it has changed this year, but certainly for the previous years nursing students did not actually go and be with a patient until mid second year. This year they are, in their first year, having 10 weeks of one day a week of aged care and being with patients, clients and residents. That will improve that but certainly the attrition rate—and I am sure Dr Gerald Farrell will explain that later in the day—has been when they have finally got to mid second year in the hospital. Then we have had a loss of nurses through the program. The second time of

danger is their postgraduate program—the lack of support and finding it all too stressful for them to stay nursing.

Ms Burke—I think another time that nurses drop out is when they become parents. They are looking to go back into nursing and there is no support. Child care is an issue for working women. If you are required to work an evening or night duty it becomes more critical. Nurses that are in these temporary pools are not able to get regular shifts. They need to know their shifts to establish their child-care arrangements, say, for Tuesday and Wednesday nights on a regular basis. All nurses are expected to do day, evening and night rotation, so every 10 weeks you need to change your child-care arrangements. I think there are a lot of experienced women who would take on that role to fill those gaps but because of inflexibility they cannot. I also think one of the biggest things is the lack of a work force planning tool or acuity level here. Nurses have been just covering for too long. Every time we ask about this we are told, 'No, we can't look at it.' I think it is time we did look at it.

CHAIR—I understand that you have a new enterprise agreement. I understand from what you have been telling us that, while you have ticked off on say 10 points, only five of them have been implemented.

Mr Kleyn—That is correct.

CHAIR—Is that more or less right?

Ms Burke—Yes, that's right.

CHAIR—One of those was a preceptor allowance. Has that been implemented?

Mrs Ellis—That has been implemented.

Mr Kleyn—Yes.

Mrs Ellis—There are some quite strict guidelines there. The policy that the department drew up did not include second-year undergraduates. It only included third-year undergraduates. It did not include students from overseas. It did not include new staff orientation, which is quite clearly a time when you need to precept those new nurses.

CHAIR—Are any of you old enough to remember the 'good old days'?

Ms Burke—Oh, yes, and they weren't all good either.

CHAIR—We have got you on the record; that is wonderful. I went through medicine but, because I was a woman, in those days most people thought I was a nurse, which was fantastic; I travelled with the nurses and learnt a lot. They told me a lot of things. One is that there was always a chance to go off-ward and find in the nurses home a mate who also had the experience of working with the same dragon or under the same pressures. So there was a lot of de-rolling. This is not so available, particularly if you have to leave nursing, race down to the child-care

centre, collect your children and so on. Do you see any way in which this could be addressed or is it a matter of saying, 'Tough; if you're nursing, cope with it'?

Ms Burke—That is a very moot point. You could be a young woman or man, a recent graduate, flatting, whether it be in Tasmania or interstate, with a lawyer and, say, a commerce person. You might have left a position in an acute setting—say, A&E—or on a ward where you have been exposed to situations which mean that you do need that debriefing. The old tutors and nurses homes were great places for that to occur, and I do not think there has been recognition of the stress that is placed on partnerships. Relationship breakdown occurs for many reasons, but certainly that would be something that I personally would find difficulty coping with.

CHAIR—In those old days, nursing students were on the wards more or less from day one.

Ms Burke—After six weeks.

CHAIR—They probably had a brief introduction—

Ms Burke—Six weeks and you were on.

CHAIR—and then you were on. You were a one-striper, and you were definitely at the bottom of the pecking order. But within 12 months, 'Bravo! I have two stripes. There are now people I can peck.' In fact, there was a lot of supervision going on all the time, and the matron in charge of the ward actually did have to keep an eye on people. I know there were nurse educators and so on but there was never a nurse educator on the ward.

Ms Burke—No.

CHAIR—You would then go back and perhaps talk to your tutor about it in your classes. Can you tell me a little about the person whose role is to precept—I am learning this new word—or supervise the education of the incoming new students, students on their prac experience, people returning to nursing et cetera? How do they fit with the other comparably qualified nursing staff who are going like bats out of hell to cope with all the work?

Ms Burke—They take on a load of clients, so it would be a reduced load. It was an integrated part of practice when I entered, so I do not know how it actually started. It was called the hospital based program. The preceptor nurses had conjunct appointments with the university, but they were actually paid by the hospital. I worked with sick kids in Toronto, in a major teaching hospital that was linked by tunnel to the University of Toronto. They were part of the staff of the hospital. That was in the public sector where I worked.

Mrs Ellis—Can I make a comment about the debriefing that you were talking about earlier. It is an unbelievably important part of nursing culture and practice to debrief prior to leaving the ward at the end of the shift. At the moment we have got some concerns with the taped handover coming into nursing, because that handover time is the time when we do debrief. When you are passing over the patients to the next shift, you tend to have that time to talk about any issues that have arisen during that shift. We are concerned that, with the introduction of the taped handover, that stops that debriefing time between nurses. They go in there, sit and listen to the tape and then they go out, and they have not had the time to have that debriefing. I think we are

really trying to protect that debriefing time, not only for the handover period but also for the nurse and her wellbeing.

CHAIR—How long have we been on taped handovers?

Mrs Ellis—It has been introduced in Tasmania in the last four years. A lot of the other states do have taped handovers. Obviously, for clinical decision making, there needs to be some time when both nurses are there, but we do not have the whole incoming staff sitting together and talking with all the outgoing staff and having that debriefing which we used to have. That will have some implications as well.

CHAIR—One of the other problems we have heard over and over is that many of the nurses in their first year out as graduates hit the wards gobsmacked. Sometimes it is because of a feeling that, 'Gosh, this is what a ward really looks like,' and sometimes it is because they have not had enough clinical experience, not just of particular illnesses or nursing needs but of the whole culture. That is because we are told that there is not sufficient time in the undergraduate years for clinical placements. Can you comment about that in Tasmania particularly? You told us that there are lots of nurses trying to get into nursing but there are not enough places? What is the reason that there are not enough places? Is it because there is not enough clinical time, or is it because there is just not enough money?

Mr Kleyn—There is not enough money for universities to provide it.

Mrs Ellis—It is the Commonwealth funding that actually dictates the number of places in nursing in Tasmania. All the School of Nursing is based in Launceston. It is all in the north of the state.

CHAIR—Why is it there?

Mrs Ellis—That is a big issue. Nurses actually want it to be in the south as well.

CHAIR—I do think we need to hear on the record: why is it there? How long has it been there?

Ms Burke—It is a political decision that was made at the time with the governments in power when it was being set up.

Mr Kleyn—At one stage the university was more evenly divided between the north and the south. You have to recognise that in Tasmania, if Hobart has something, then Launceston has to have it as well. I think it was a political decision to put the School of Nursing up there to even up the balance, if you like. I do not know if there was any specific reason, other than Tasmania's traditional parochialism.

CHAIR—It certainly seems to me from what I have heard from people living anywhere except Launceston that this makes life very difficult. They have to find accommodation and outside hours work because there is not enough work for them in the region to get their part-time casual work.

Mr Kleyn—Yes. Also, if you are living in Hobart and thinking of doing a nurse undergraduate course and your options are Launceston, many people choose to go to the mainland if they have to leave home anyway.

CHAIR—Would any of you make a recommendation that nurse education should be available in Hobart too?

Mrs Ellis—We would support that. I think it is important that it is based in both centres.

Mr Kleyn—Also, given that the major teaching hospital in Tasmania is the Royal Hobart, it seems somewhat illogical that the nursing school is exclusively based in Launceston.

CHAIR—How does the clinical experience get arranged? I understand you are saying it is changing now and that nurse students are getting more access to clinical work. It certainly seems to me, from what we have been hearing so far, that it is clearly not enough.

Mrs Ellis—It is the early introduction that is so important. The fact now that they will be introduced into clinical practice in the first semester of first year will make a marked difference.

CHAIR—By how long? Will that be a week on the wards?

Mrs Ellis—No, one day each week.

CHAIR—Do you have a comment about that before I make up my own mind on what I think about one day a week?

Mrs Ellis—From our perspective, we absolutely support tertiary education for nursing, but it needs to be integrated into clinical practice, and that has to be supported clinical practice. I am not relying on the current nurses to mentor and assess the students coming in. It needs to be a planned process. I am hospital trained as well. Certainly the first year that we went out we were only doing very basic nursing care. That is exactly what these nurses will be doing in their first semester now in the aged care setting as very basic nursing skills, and that is what is required.

CHAIR—Do you pick up the culture of a hospital in one day a week?

Mrs Ellis—We are not actually educating nurses just to work in the public sector. We are educating nurses to be health promotion nurses, to work in the community, and to work in rural and remote areas. They do not have to be just trained, as they used to be trained, to work in the public sector in acute hospitals.

CHAIR—That is true. I am interested in commenting on that. Are you suggesting that one-day-a-week first-year nurses who think they might work in aged care should go to an aged care place?

Mrs Ellis—I think it is a wonderful introduction to basic nursing care.

Ms Burke—I personally feel it would turn many young people off nursing altogether.

CHAIR—What? Being on the wards?

Ms Burke—No, going to an aged care facility as a first-year nurse, as a young 18-year-old. I believe a mature age student would look at it differently. They have had more experience of life. I do not think it would encourage an 18-year-old to go to an aged care facility for one day a week.

CHAIR—The message that has come to the Senate inquiry is that nurse education will continue at universities. What is under discussion is how best to make the university education fit with the need for clinical experience. Everybody has told us that the current arrangements for clinical experience are insufficient. Everybody seems to say, ‘If you put them into hospitals, it will look like we are retreating from the universities.’ I think it is clear to this committee that that is not what would be understood by that. I do think we have to ask—and I would be very interested if you could put comments on the record now or if you could drop us a few notes later on—how you see that could be improved. Why is it not possible to have a university education in a hospital? Doctors have been doing it for a long time. I wonder what it is that is blocking this for nurses.

Can I ask you to also comment on another point. There is not enough time for clinical experience because nurse education in universities is now restricted to the 26 weeks of the year or thereabouts. There is no capacity for clinical experience to happen outside that time. Is that something that is of concern in Tasmania?

Mrs Ellis—A lot of student nurses do work as personal carers in aged care during their time. I am aware of other states that do have undergraduates working in their time off. We do have an accelerated program here too, so that people can continue their university semester through the summer holidays and advance and complete their course midyear. It has been a wonderful boon for Tasmania to have graduate nurses coming out of university in July, as well as the end of the year, to even the distribution of new learners coming on to the wards.

CHAIR—Is there anywhere in the mainland doing that?

Mrs Ellis—I am not aware of it. I cannot comment on that one.

Ms Burke—It is at the end of their second year that they can actually do that.

CHAIR—Maybe I should ask the university to outline the curriculum. I note your points about different curriculum from one state to another. I think that is very important. Registration presumes that if you have been ticked off, got your RN certificate in Tasmania and you are registered there, then when you apply for registration in another state you might have to send some documentation. But the best documentation is that you were registered in Tasmania.

Mrs Ellis—That is right. We have national competencies that we are meeting for registration. The ANCI competencies are our national competencies.

CHAIR—We have been concerned to note the number of nurses who are leaving the nursing profession in their first year out. They are shocked by the culture and the demands and the pressures and everything else on the wards. We have been very aware that a number of people

have been talking about increasing those clinical experience opportunities through all the years. You do not want somebody halfway through second year of a university degree to discover they do not want to do nursing now they have actually got a taste of it. That is a terrible waste of their time, university dollars and hospital expectations.

Mr Kleyn—It has to be supported, rather than just getting a clinical placement and they are there. The existing nurse work force is expected to provide the support and mentoring and precepting.

CHAIR—Absolutely.

Mr Kleyn—There have to be better support structures from the university, and I think they are lacking.

CHAIR—From the university?

Mr Kleyn—There has to be some method when the nurses do go on to the wards. Currently it is up to the existing nurse work force to provide that support. Given the pressures they are under—

CHAIR—We want to introduce or reintroduce the nurse tutor?

Mrs Ellis—The clinical nurse educator.

CHAIR—What do we call them now?

Mrs Ellis—The clinical nurse educator.

CHAIR—CNEs.

Mr Kleyn—Nothing as simple as a 'tutor'!

Mrs Ellis—But they would also be called different things in each state.

CHAIR—We cannot use words that everyone understands, can we? You suggest that traineeships should be offered in areas of high unemployment. What sorts of traineeships? How do you see they would go?

Mrs Ellis—We currently have enrolled nurse traineeships in Tasmania. They are working quite well in the aged care sector. We would like to see greater opportunities for more training of enrolled nurses. That would be looking at once again making sure that their traineeship would be covered with a clinical educator so that we are not relying on the acute sector nurses to look after and educate the trainees. We just cannot put that pressure on to the nursing work force.

CHAIR—The area of specialist nursing need, whether it is traineeships or whatever, seems to be a problem. You may get sufficient in the end for your base run of RN1s, but it is very

difficult to get the nurses into specialties like psychiatric nursing, mental health nursing, aged care and so on. In times past—again, the halcyon days, at least way back then—nurses in their undergraduate three-year course would have three-month blocks. I think they were usually three months; at least they were where I was doing my work. You would have three months on the psych wards, three months in paediatrics and three months looking after the oldies or whatever. That gave nurses a sense of what it would be like to then move into that specialty. Do you have any views about how we can encourage nurses to get experience in the undergraduate years in special areas like mental health nursing?

Ms Burke—Nurses in their third year opt to do a placement. They may do it in the area that I work in, which is family, child and youth health, which is community based with families, in the mental health area or in the aged care area. So they do a placement at that time in their third year. They actually choose the area that they would like to be exposed to, the one that they are interested in, and they may make the decision to work within that area. They would need, under the present arrangements, to do further tertiary study, a graduate diploma in that specialty area, whereas in the past I did 12 months for my midwifery, so much more for child health, so much more on top of the base. Now, after their graduate year, they need to do a graduate diploma.

Mr Kleyn—We are finding that those people who were hospital based who have achieved post-basic training qualifications at a hospital are not going to be recognised. The cost of undertaking postgraduate study is a significant cost.

CHAIR—It is a very overwhelming cost.

Mrs Ellis—It is a $10,000 cost, plus the loss of income for that 12 months. So it costs considerably more than $10,000 to do that.

Mr Kleyn—Some 26 per cent of respondents to a survey indicated that cost was the major factor for not undertaking postgraduate study.

CHAIR—Are there any recommendations for any of that postgraduate study to be available in the clinical situation?

Mr Kleyn—The difficulty there is that the department at present is refusing to recognise that kind of postgraduate qualification, so there is no incentive there either.

Mrs Ellis—For those undertaking the graduate certificate in mental health or the graduate certificate in midwifery, they all work 0.5 in the clinical setting whilst they are doing that postgraduate study, so they have half the time at university and half the time is clinical time, on the wards.

CHAIR—How does what you have just said fit with the fact that they have to lose money and pay $10,000?

Mrs Ellis—They have to pay $10,000. Not all of them have the clinical placements. There are only a certain number of funded positions for rotational graduate positions, so those who are lucky enough reduce their income down to 0.5. They may have come from level 3 or senior positions but they have to drop back to the level 1 position rate.

CHAIR—This has been extremely interesting and very helpful. It is a great way to have started our hearing today. We have run over time, and I do beg your pardon, but it is very helpful for the committee to get into the crevices regarding what you have told us in your very useful submission. Thank you very much indeed.

Mr Kleyn—Thank you for the opportunity.

[11.43 a.m.]

LAVERTY, Ms Moira, Chief Executive Officer, Nursing Board of Tasmania

CHAIR—I welcome Ms Laverty from the Nursing Board of Tasmania. We prefer all evidence to be given in public but should you wish to give 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. The evidence to the committee is protected by privilege and should you give us any false or misleading evidence this would constitute a contempt of the Senate. You are not required to answer questions on advice that you may have given in the formulation of policy, which is probably more applicable to you than to some other witnesses. We have before us your submission No. 838. Do you wish to make any alterations to that submission?

Ms Laverty—I do not wish to make any alterations. We have prepared a statement, but I am happy to go with—

CHAIR—Would you like now to give us your opening statement and then we will field questions.

Ms Laverty—I would also like to table two documents. One is our submission to the National Review of Nursing Education and the other is our response to their draft report.

CHAIR—Thank you.

Ms Laverty—The Nursing Board of Tasmania is the nursing regulatory body for the state of Tasmania and governs over 6,000 registered and enrolled nurses. Nursing is the largest occupational group within the health care work force. The board is extremely concerned with the severe shortage of nurses being experienced nationally and globally. Demands for skilled nurses are increasing faster than the supply of nurses. What is now called a nursing shortage is the outcome of a complex composite of market, societal, economic and technological forces that have eroded the ability for the profession to respond to cyclical changes in the need for nurses. Nursing is regarded as a caring profession and care itself is regarded as the central focus and essence of nursing. The need to understand and improve caring has never been more important given the increasing technological complexity of health care delivery.

According to recent Morgan and Banks opinion polls, nursing, despite all the challenges, maintains its standing as amongst the most highly regarded professions by the community. Nursing portrays the face of health care in the community far more frequently than does any other member of the health care team. For patients receiving community or hospital care it is nurses who provide the majority of that care. Care rather than cure distinguishes nursing from medicine and it is care that patients come into our health care settings to receive. With the introduction of consumer focused standards there is a need for nurses to understand more fully the consumer perspective of care delivery.

The board would like to recommend a number of initiatives and I will run through those. Some are contained in the tabled documents. It is envisaged that there will be a number of initiatives which will come out of both the Senate inquiry into nursing and the Review of Nurse

Education. The board would strongly support the establishment of a chief nurse at the Commonwealth level that is appropriately funded and supported. This position should also be supported by a nursing forum made up of the Australian Nursing Council, the Royal College of Nursing of Australia, the Australian College of Deans of Nursing and the Australian Nursing Federation which should be developed with appropriate infrastructure to support the position of the chief nurse. The board believes that a federal advertising initiative should be undertaken to promote nursing at school age which focuses on the portability, positive professional image within the community, flexibility et cetera and that support be given to the principle of wage parity for nurses irrespective of their practice setting. In addition, a strategic approach to developing and sustaining partnerships with schools to increase the promotion of nursing as a career option from year 6, including promoting nursing as a career for males, should be adopted.

It is important that nurse regulatory authorities continue to develop the role and importance of the national body—the Australian Nursing Council. Whilst there is increasing consistency between the states and territories in nursing legislation and practice, there continue to be major inconsistencies from the variety of health acts, mental health acts, drugs and poisons legislation et cetera. National consistency is a high priority of the nurse regulatory authorities which has been assisted by the Mutual Recognition Act 1992. The board believes that leadership in nursing should be encouraged at all levels of the profession and in particular that support be mobilised for the clinical leadership position of the nurse practitioner role across the country as community needs are identified. There is a strong public interest argument to having sufficient qualified nursing staff to provide health care to the population. The current shortage is quite obviously detrimental to the community and a current example in Tasmania has been the cancellation of cardiac surgery due to the lack of appropriately qualified and skilled nursing staff.

The ageing of the nurse population in Australia has been influenced by a number of factors such as the age at which students enter nursing education. This trend has seen an increase in mature age students. This trend has implications for the work force as the median age of the general nursing work force in Tasmania is over 40 and for midwives that age jumps to 54. The board believes there is a strong relationship between work force and educational issues. Nursing shortages are particularly evident in rural and remote areas, specialty areas, including mental health and aged care, and in many specialised areas of hospitals including peri-operative care, emergency nursing and intensive care.

Lack of access to relevant postgraduate education programs results in nurses leaving the state to gain additional qualifications to further their careers, thus depleting the state even further. To meet this clearly identified need, relevant postgraduate and continuing education programs should be made available and accessible through flexible delivery of programs at an affordable or subsidised cost at both the state and federal levels. Cost is a major barrier to many nurses aiming to gain postgraduate qualifications in specialty areas.

The board is required, pursuant to the Nursing Act 1995, to determine the standards for the accreditation of nursing schools and courses in nursing. The board agrees in principle to the national accreditation of all education programs for nurses to be undertaken by the Australian Nursing Council to ensure national consistency and avoid duplication of effort. The board's view is that dedicated funding should be made available for Bachelor of Nursing programs. This is to ensure adequate places for students who wish to undertake programs, including funding for clinical placements, clinical teachers and preceptors who are in a structured relationship for an

agreed period of time with their nominated preceptee. This effort would be compromised if there was not also support for a transitional or graduate year program funded federally. This support across all sectors would allow graduates to have a decreased patient load and be supported by specialist preceptor training. It is essential that, following graduation, the new nurse graduates be supported so that they are not expected to hit the ground running, which we hear all the time. Preceptor training is an essential part of this, and a national approach should be adopted to ensure that preceptors have the necessary skills, knowledge and attitudes to support nurses within the practice setting.

Support and funding should also be given to the re-establishment of clinical educator positions and conjoined appointments within the tertiary sector to support nurses in practice. The board also supports that nurse education programs need to remain under the leadership of appropriately qualified and experienced registered nurses and that pre-registration programs for entry to practice remain at bachelor level conducted in the tertiary sector.

It is strongly suggested that working parties be established involving the public, private and aged care sectors, education providers and nurse regulatory authorities to review the number of clinical placements available to undergraduate students. There should be funding made available to allow the introduction of graduate nurse rotations into specialty areas. The long-term benefits would include recruitment into specialist areas and would allow support and supervision by experienced nurse practitioners. From a Tasmanian perspective, there should be consideration given to providing the Bachelor of Nursing program in both the north and the south of the state to attract state-wide entrants into the program at the undergraduate level.

The re-entry of nurses to practice is of concern to the board, particularly in regard to the cost to the individual to undertake these programs and the difficulties being experienced by participants in gaining appropriate clinical placements. To assist in addressing the current nursing work force shortage, programs should be made affordable in both the acute and aged care sectors or consideration should be given to funding through scholarship schemes facilitated by government funding. The re-entry to practice programs should be delivered using flexible teaching methods such as self-directed learning packages, computer simulation and appropriate clinical practice placements.

The board's scope of practice guidelines uphold that enrolled nurses work under the supervision of a registered nurse. With emerging roles for enrolled nurses, there should be a national approach to decide the level and type of supervision which is required in various settings. There should be a nationally consistent approach to education for enrolled nurses to be at a minimum of a certificate IV level. The board fully supports the recently approved competencies for enrolled nurses and endorses the generic role statement for an enrolled nurse developed by the Australian Nursing Council. The board sees the issues around the regulated health care worker as of extreme importance to ensure that the needs of health care consumers are not compromised. The number of unregulated health care workers—with titles such as personal carers, extended care assistants, support workers and assistants in nursing—has been increasing in the aged and disability care areas for some time and is increasingly emerging in other health care settings.

The Nursing Act 1995 and the Nursing Board of Tasmania regulate both registered and enrolled nurses. Health care is under enormous pressure to substitute registered and enrolled

nurses with unregulated health care workers. Nurses are regulated to ensure the community is provided with appropriate, safe and expert nursing care. However, there are no systematic or consistent controls over the level or quality of care given by unregulated health care workers. Consideration should be given to developing a regulatory process for this level of worker in a nationally consistent approach to ensure that they have the relevant knowledge, skills and competence to undertake the care activities that they are being required to perform and that relevant processes are in place to manage situations where the standard of care provided falls below the accepted standard. As the activities associated with this level of worker are an adjunct to nursing care, the board believes it is appropriate for the nurse regulatory authorities in each state and territory to undertake this role. This issue, we believe, needs to be given priority status.

The board currently supports indicators such as recency of practice, self-assessment of competence, self-assessment of health status and adherence to the Australian Nursing Council code of ethics and code of conduct for nurses in Australia. These indicators are supported by a random audit promoting quality control. The board has also just given 'in principle' support to the adoption of continuing education as a condition of annual licence renewal.

The Australian nurse regulatory authorities are regulatory leaders internationally in the regulation of continuing competence to set minimum standards aiming towards a consistent national approach. It is strongly recommended that a process of self-assessment be the basis for determining the continuing competence of an individual practitioner and that it is implemented within a quality improvement framework nationally. There needs to be a strong recommendation to change the culture of nursing within health care environments—for example, graduate nurses being put in charge and being unable to cope with the responsibility and stress and, therefore, they leave the profession.

Unresolved issues that affect nurses such as patient loads and acuity within the acute setting, job stress, length of shifts and professional autonomy are again surfacing. Nurses feel that caring for their patients is being forced into less and less time, and that their employers undervalue them. In recognition that nursing provides a 24-hour service in many contexts, appropriate support services should be made available to assist staff. There should be a strong message sent to both nurses and consumers of health care services that violence of any description is not acceptable, and that increased health promotional messages be sent out to this end.

The board is concerned about the increasing casualisation nature of the nursing work force and would respectfully suggest that some of the policy directions of employers of nurses have driven this negative trend. It believes that it is detrimental to safe and quality health care delivery for the community. To now combat the competitive edge that agency nursing has in some areas, there has to be an injection into promoting the value of nursing within the community. There has to be a promotion of the advantages of working for individual employers and the encouragement of more flexible management practices—that is, to introduce a more nurse friendly environment to decrease the migration of nurses to the agencies.

Nursing work force planning needs to be a national role driven by the Office of the Chief Nurse at the federal level, in consultation with the Australian Nursing Council, Australian Nursing Federation, Australian Council of Deans, nurse regulatory authorities and employer groups, public, private and aged care. The board would also support national research on work

force and planning to enable the generation of reliable and valid data prior to future decision making processes in regard to nurse education, recruitment and retention. The future promotion of nursing as a caring profession will be reliant on a number of factors as discussed within this paper, including recognition of the vital place of nursing within the health care system.

CHAIR—Thank you very much.

Senator TCHEN—This is a very comprehensive submission. I will not have time to go through all this with you. You identified a current shortage as being a consequence of the complex social and economic forces, which reduced the profession's ability to respond to cyclical changes in the need for nurses. Can you enlarge on what you mean by 'cyclical changes'? This is an important issue. If the need to change is cyclical then, firstly, we need to identify the cycle and, secondly, we need to respond to the cycle. It seemed to me that, in a lot of the remedies you are proposing, you actually have not talked about this need to respond to the cyclical changes. Can you explain this and how you identify the cyclical changes?

Ms Laverty—Most of us who have been around a reasonable amount of time have seen nursing shortages come and go. They have been managed in varying ways. Certainly, coming to one of my final points, a lot of effort is put into collecting data, but it is neither consistent nor is it validly used, at least in the board's opinion. Therefore, over the years, nursing number providers through education—whether they were hospitals previously, or now in the tertiary sector—have upped and downed their numbers based on, I would suggest, very faulty data at the very least.

The numbers of nurses being trained have also responded often to economic conditions in hospitals whereby nurses are employed during the good times and then they are the group to be axed when economic situations arise and hospitals are forced to contain their services.

I think that also picks up on one of my other points that because of those economic restraints employers in many ways have changed the nursing work force from what was essentially in previous years a full-time work force predominantly to very much a casualised work force, whereby there is an expectation that nurses are there when we need them but when we do not need them we will put them to one side. I think over time that has made nursing less attractive because it certainly has not got that consistency.

I turn to some of the issues in terms of attracting people to nursing. When I trained, which was a few years ago, you were a nurse, a secretary, a hairdresser or an office worker. They were the predominant roles for women. That is no longer so. Girls coming out of school can go into any career they choose. At this point in time, whilst it may be very valued by the community—and I think the statistics are there for that—nursing does not have that same attraction for people from school or from the universities.

Senator TCHEN—What you are actually saying is not that there is a cyclical change in the need for nurses but there is a cyclical change in the supply of nurses?

Ms Laverty—I think there is supply and demand. Speaking from my previous role as a director of nursing, the economic rationalisation of our services were about, 'You have a budget of this and therefore you have got to downsize.' If that meant closing beds or services, that is

what you did. Therefore that in some ways is one of the cyclical changes. Then either a new government comes in or there is a new budget initiative or something positive happens and you are then about opening services and beds and there is a need for nurses. These nurses in the meantime may well have gone into other jobs and professions. So it is a supply and demand type situation.

Senator TCHEN—I am just trying to bend my mind around this question. Quite a large proportion of your proposal said the remedy for this problem of the shortage of nurses is in the education area. If this is a market determined shortage, how would the increase in education resolve that problem because basically through education you are providing more nurses? But firstly, you are somewhat behind the need. You are trying to catch up with the demand. Once you get the nurses trained, they might saturate the market or the market might adjust itself to the number of nurses available and suddenly you have new nurses coming in. That in itself would create a cyclical problem, would it not?

Ms Laverty—Certainly from the Tasmanian perspective, my understanding is that we do not have a problem filling the places that are available in our university for nurse graduates or undergraduates. There are many opportunities for those nurses to be employed. The government in Tasmania, over the last number of years, has supported the transitional programs of the graduate nurses years, however they are termed. Because there is not that support in the workplace through ongoing education and development, a lot of people will lose a lot of those nurses in that early period. I think we would have to go a long way down the track to saturate the marketplace. I cannot see that major change is going to happen. Nursing is still predominantly going to be a female occupation. There will always be enormous movement of people through the work force who often start out as full-time employees and then become part of the part-time work force through family commitments et cetera. I am not sure that really answers your question.

Senator TCHEN—Many of your suggestions focus on having a national focus in terms of training, curriculum and conditions. Yet at the same time you also identify that they are particularly related to local conditions—for example, to the nursing needs for rural and regional remote regions—you actually suggest that rural nursing should be a specialty. If you have a national focus, it responds fairly slowly to local variations. How would the two fit together?

Ms Laverty—Regarding our view and push for national consistency, there is a lot of discussion—which you have probably heard already—of support for a national registration, with some lack of understanding of our federal system and how likely national registration is going to be. That does not stop the states and territories being very active in their work through the Australian Nursing Council to develop that national consistency. With the Mutual Recognition Act, we now have no option—and I am putting this as a positive issue—other than to register nurses wherever they have trained within Australia and/or New Zealand through the trans-Tasman Mutual Recognition Act. Therefore, it is imperative that we have consistency because we have no right to not register them but we have no control over how they are educated in New South Wales or Queensland et cetera.

The push for national consistency is very much from our regulatory point of view that, if we are going to register nurses here in Tasmania, we would like to think that they would be equal to any nurse that we produce locally. For example, there is no recency of practice or requirement

for competence in New South Wales. So a nurse in New South Wales can effectively come back after 35 years and re-register as a nurse. Having re-registered as a nurse in New South Wales, that person would automatically be able to register anywhere in Australia. The rest of Australia says that really there has to be a recency of practice. So it is those national inconsistencies that we would like to see addressed.

Senator TCHEN—You are not actually looking for an enforced national standard as such?

Ms Laverty—I think that would be detrimental. I believe there is value in having the differences. If we had, for example, accreditation of courses at a national level, the board is not saying that the same course has to be run in New South Wales and in Queensland, but that there be a framework against which all courses are accredited. You would never get agreement between individual universities, never mind between states, but at least there could be a consistency in how the courses are accredited. Each of the boards and councils has that role of accrediting nursing courses within their state. We do believe that is a duplication of effort that does not need to occur.

Senator TCHEN—When you talk about a national nursing curriculum, you are talking in the same context as well?

Ms Laverty—Exactly. We are certainly not saying that it has to be the same curriculum, but simply that there be a consistency and that the standards are there.

Senator TCHEN—You have pointed to the use of unregulated workers in the health sector as a problem. How significant is that problem and how would we address this? Is more training a solution or are there some other ways?

Ms Laverty—It is a major problem. Obviously, a lot of our information is anecdotal. In terms of dealing with the problems, which is part of our role as the regulator, again and again we come up against problems, particularly in the aged care sector, where we have a predominantly untrained, unqualified and unregulated work force whose standards are maintained at the whim of the employer. Many employers are very conscious of their duty of care. However, there is nothing to state what that standard should be and there is very little that anyone can do when those standards fall by the wayside. I will push for that standard, or at least for some control being put in place, so that when things are going wrong there is a body that can say, ‘This is the standard that is acceptable to the community; everyone has to meet that standard and, if not, these are the consequences that will occur’—in the same way as happens for our regulated health professionals, be they nurses, doctors, physiotherapists et cetera.

CHAIR—It used to be that nurses had a loyalty to the institution they trained with, for example, ‘I am a St Vincent’s nurse, I am a Royal Hobart nurse, I am a Royal Melbourne nurse.’ Have you met any who say, ‘I am trained through the University of Launceston’?

Ms Laverty—No. I do not think the branding is there in the same way.

CHAIR—It was raised with us at, I think, the Melbourne hearing that one of the challenges is that nurses may belong to a tertiary institution but they do their clinical experience in a number of places so they do not even pick up such brand loyalty. The university places people

at this hospital, this aged care institute or whatever, so nurses cannot actually say, ‘I am a Royal Hobart trained nurse.’ Do you think there is any merit in that?

Ms Laverty—I am not really sure because I trained in Scotland. In fact, I trained through a college although it was a hospital based course and the Lothian College incorporated five hospitals. Then you also went somewhere else to do psychiatry and somewhere else to do bits and pieces here and there. I am a hospital trained nurse but I do not have that loyalty to a particular institution and I do not know that that was detrimental to me. I think there is merit in linking universities more closely with the clinical placement providers. That is probably one of the areas that could be improved on greatly and I do not see those providers as having to necessarily simply be the Royal Hobart or Launceston General. We have a number of private providers. We have aged care facilities that are now of such an acute nature that they provide very relevant clinical practice levels for nurses in training.

CHAIR—Does the Nursing Board of Tasmania have anything to do with seeing those places are providing adequate education or is that left entirely to the universities?

Ms Laverty—No. Through our accreditation process at the university we have the ability to make comment on the ratios of educators to students and how that happens in the clinical placements.

CHAIR—You could actually say that you have had a number of nurses report to you that they went to do nursing clinical experience at situation X and all of them uniformly report that they learnt nothing. They were just expected to scrub bed pans and then return. I am being excessive here but do you act on a report that a certain clinical experience situation is not delivering clinical experience?

Ms Laverty—Yes, we would.

CHAIR—How do you get to hear about it?

Ms Laverty—We would hear about it mostly from the profession itself and that is not normally from the students. That is normally from people in the clinical settings or are observing what they see as not appropriate placement of students or not appropriate supervision of students.

CHAIR—Do you have anything to do by way of assisting students?

Ms Laverty—We don’t really, no.

CHAIR—You don’t actually take over responsibility for their accreditation until they have graduated?

Ms Laverty—That is right.

CHAIR—Ticked off through TAFE as an EN or ticked off through the university as a RN?

Ms Laverty—Yes.

CHAIR—Can you provide to the committee some information on the range of things the board does. I do not want a thesis. You may have a little booklet. Do you actually get to sack or strike off nurses who have behaved unprofessionally?

Ms Laverty—Yes, we do.

CHAIR—Also, can you provide us a paper on exactly what sorts of things nurses would have to do to be called into question? What are the range of offences a nurse would have to do to qualify for being deregistered and who are the people who are able to bring a case against a nurse? Is it their peers or can a member of the community complain et cetera?

Ms Laverty—Basically, the legislation states anybody who is aggrieved by the conduct of a nurse, so that can be literally anybody, and it does not even have to be related to the practice setting. It could be that they are aggrieved that a nurse is behaving in a particular way and bringing disgrace to the profession. It is very broad.

CHAIR—Do you ever strike off people because they have got drunk at a restaurant or is your deregistering of them related only to their insufficiency as a nurse?

Ms Laverty—No. We actually deregistered a nurse last year who murdered her sister-in-law.

CHAIR—That seems to be a significant qualification.

Ms Laverty—Yes. Her behaviour was not becoming of a nurse—I think that is the phrase used in the legislation. We felt that was quite an obvious case.

CHAIR—So she cannot nurse in jail?

Ms Laverty—She cannot nurse in jail, and she will have to provide us with a lot of evidence on her return to the community.

CHAIR—Why would you re-register a person who has murdered? Why would you deregister a murderer?

Ms Laverty—In this particular case it was really as much about her actions—the fact that she had made this attack on a member of the community and then left them to die in the gutter. It was the circumstances surrounding it. The act is very clear that a person has to be of good conduct.

CHAIR—So good conduct is the criterion. Is there a piece of paper that gives us the range of responsibilities of the board—accrediting institutions and places where students and nurses work, I presume?

Ms Laverty—Yes, that is right.

CHAIR—If you could provide us with that, it would be very good. On the notion of casualisation, are you able to provide for us, or should we perhaps seek elsewhere, the wage differences between the casual work force and the permanent work force?

Ms Laverty—Probably the unions would be more in a position to do that.

CHAIR—Yes, we have asked them.

Ms Laverty—It is also about wage parity between clinical settings. Nurses in aged care, for example, do not get the same wages as nurses who work in an acute care setting. Yet their role, certainly as defined by our body, is the same. We talk about attracting people to work in an aged care setting. I believe it is not as difficult as it is sometimes perceived, because the aged care settings are quite different from what they were 20 years ago. There are issues around wage parity and hours of work et cetera.

CHAIR—Do you have the same problem with wage parity within, for instance, a large public hospital where some nurses would be doing intensive care and some would be doing the skin ward?

Ms Laverty—Only in the most recent enterprise agreement under which nurses are now paid for their qualifications. It is not my area, but my understanding is that the EBA may have some loopholes in it, or it may be a bit loose, if I can put it that way, in that for nurses who have hospital based certificates there is a wrangle on, whereby they really only want to pay certificate allowances to those who have qualifications from tertiary settings. Certainly, the board would not support that. If somebody has an intensive care certificate and is deemed fit to work in an intensive care unit, then whether that qualification came 15 years ago from the Royal Hobart Hospital or yesterday from the Tasmanian School of Nursing would not be our concern. The concern is that the individual has proven they have the expertise and they have gone through an accredited course to gain that qualification. It really belittles many nurses across the country, and certainly in this state at the moment, to suggest that a qualification from one place is worth more than a qualification from another, particularly when we have been in a transition from hospital based training to tertiary based training. It is ludicrous.

CHAIR—Do you have many fights with your nurse university colleagues?

Ms Laverty—We actually have a very good relationship but we have a lot of discussion.

CHAIR—Given what you have just said, I should have thought you have been in some very fulsome discussions. It is a matter of major concern—and I am very interested in your comment about that—to any number of people I have spoken to over the last 20 years, through this whole transition phase, that, ‘My qualifications really stand for nothing; all I am qualified to do now is some kind of university degree. I’ve got what is equivalent to a diploma. I’m not going to be in the game.’ Having nursed in public hospitals, in intensive care, aged care or wherever, for 25 to 30 years, many of those, particularly women, were told, ‘You’re not worth anything unless you go back and do a university degree.’ You have just said something quite contrary to that; that is, if someone has a certificate to say they are qualified to be an intensive care nurse, it does not matter to you whether they have their expertise in that certificate in the situation or through the university.

Ms Laverty—I think it is outrageous that we have this situation because these courses are quite new in the tertiary setting, particularly in Tasmania. Who preceptors or educates those nurses in the intensive care unit, taking that as an example, or in the midwifery area or in any other specialised area? You are talking about a small number of tertiary qualified who are being preceptored, trained and supported by nurses who have trained in a hospital setting. I do not think you would find them saying that that is not valid and useful.

CHAIR—How has the board accommodated the transition? Have you actually had to rethink the criteria for registration across the whole—

Ms Laverty—The board really only has a limited role in what it actually does. We can make comment, and we certainly take opportunity to do so, but we actually only register those who are protected under title under the legislation. So we register general nurses and we enrol enrolled nurses and we register midwives. We no longer have a register for all of those specialties, which we used to in previous legislation. Certainly we would look at those. We do accredit the courses and, again, our concern there would be probably about—and I think that we have expressed it in some of our documents—the difficulty that people have in gaining relevant, appropriate and enough clinical practice.

CHAIR—That is a very powerful point that has been made with us over and over again. Did you mention licence for continuing education?

Ms Laverty—Yes. The board has being discussing the issue for some time, and I think it is an issue that has been out in nursing for many years—that is, that medicine has the CME point system. Certainly our understanding is that a lot of the research around the world does not show conclusively in any way that insisting that people undertake education will make them more competent or more able. You can take the horse to water but you cannot necessarily make the horse drink. We certainly would not see it as replacing any of our existing requirements, but we do believe that it is timely to make a statement to say that lifelong learning or continuous education is a requirement of a professional—whether they be a nurse, lawyer or doctor—and that we will look to making it a condition on licence.

CHAIR—This seems to be a smidgen contradictory to what you were just saying about a person who got their certificate for intensive care nursing 15 years ago, and they are the people who are training the new university graduates. I am being a bit devil's advocate here. I would be interested in your comment about people who are continuing to practise and presumably keeping up to date. They are certainly not strictly in continuing education or would you call that within the ambit of continuing education?

Ms Laverty—Yes, we would. I would see that we would look at that in the broadest sense. It may be about self-evaluation, self-reflection on practice; it may be that they subscribe to journals and keep up to date in their own way. They may well use the web site, recognising that people do not always have the time, money or inclination to do prescribed courses. So I do not see that our model would be looking at saying that they have been to two conferences or three seminars or they have undergone some further education that gives them a piece of paper. It is about saying that it is not good enough to train or be educated as a nurse and then do literally nothing for the next 35 years until you retire. There is an expectation that, through whatever

means is appropriate for you, you maintain your relevance as a professional. It may be about reading; it may be about a journal club.

CHAIR—How would you know that? I think self-assessment is a pretty exciting challenge, isn't it? How would you assure yourself that they had done any reading?

Ms Laverty—We were the first state to introduce an audit process for our competence to practise, so our nurses each year sign a statutory declaration to say that they are competent and safe to practise. We introduced a system four years ago whereby five per cent of nurses are audited on an annual basis. Those five per cent have to put up, so they have to be able to show. If they are working in an organisation that has a goof performance management system, for example, it may well be enough to simply put forward the most recent performance management, which should address those sorts of issues, depending on what role they are in. They may well keep a portfolio, in which case they can provide that as evidence or they may look for references within their clinical setting. They may undergo some assessments. It is, again, fairly broad, recognising that nurses work in all sorts of settings. One of them may be a practice nurse working somewhere with one GP, so we then have to think how that nurse is going to show to us that they are competent.

CHAIR—What is the certificate that you mentioned somewhere for?

Ms Laverty—It is in the Australian education framework where there are certificates I, II, III and IV. It was certificate IV. That is the equivalent to the enrolled nurse training program.

CHAIR—I think my brain will burst. They are called different things from state to state. They are called different things from the hospital to the university. Do you have a piece of paper that explains all these bits and pieces?

Ms Laverty—Of those certificates? We can certainly provide that.

CHAIR—How a nurse can be called and still be eligible to be registered. We have learned so far that there are level 1 and level 2, which turn out to be comparable to EN and RN. But there are other people who can be an RN at level 1, 2, 3, 4, 5, 6, 7 and 8 for the purposes of incremental increases in salaries. I am here on behalf of ordinary mortals who find that, if you say level 1, it should not mean three different things.

Ms Laverty—I quite agree.

CHAIR—If we say you get a certificate to do something, that is apparently different from a certificate for something. On behalf of ordinary mortals—and this one in particular—I would be very grateful if you could send us a sheet of what gets ticked off on and what they are called. It would also be helpful if you put in brackets anything else they are called. It really has been very useful to talk with you.

I will just pick up on this point you were saying earlier about developing and sustaining a partnership with schools so as to increase the promotion of nursing as a career option for girls and boys. What sort of things do you have in mind? Is that a board program or is it something the board would like to see somebody else do?

Ms Laverty—The board would like to see somebody else do it. We are a very small organisation. The board certainly would be very happy to be involved in any of that sort of promotion in whatever way would be applicable. We see it as something that should be looked at from a national perspective. We know there have been major advertising campaigns at huge cost in Queensland and in Western Australia, where they try to get across the message that nursing is a viable option as a profession and get it down to that school level. It just seems there is a major duplication within our federal system of all of us going off and doing our own thing. We think it should be done at all sorts of levels and certainly at a federal and state level. Individual employers spend a lot of money trying to get their message across.

CHAIR—Why do it when we have been told that, even in Tasmania, there is a surplus number of people applying to do nursing to the places that are available? You could actually double the number of nurses in Australia if everybody who applied to do nursing was able to get a place at university.

Ms Laverty—I think probably the university people would be better to answer that. That is not my understanding. There is a lot of licence taken in estimating the number of people who are out there battering down the door to come into nursing. If they are out there, we have not heard from them. We tend to try and keep a bit of a finger on the pulse of what is happening in terms of future directions. It is not my understanding that we are being overwhelmed with requests to join nursing.

CHAIR—In some evidence we got in the north island to Tasmania—the mainland—there was a more than 200 per cent increase in applications for nursing after some sort of advertising campaign. Even this morning our witnesses told us there were many more students in Tasmania applying to do nursing then there are university places. Of course, I think a partnership would be useful, but it might be not necessary. I want to find out just exactly what you mean. Would there be somebody promoting nursing—along with engineering and bungee jumping—for sixth year and seventh year or beginning secondary school students?

Ms Laverty—I suppose we are thinking along the lines of career expos et cetera, so that we actually give nursing a profile. However, I would put a caveat on that—and this is my personal view as opposed to the board's, because I have not run this past them—to say that, unless we sort out the problems in the working environment, we can promote and sort out the educational part of nursing as much as we like, and that is important, but you will take those same people and put them into a situation which has not changed since I started and which they will not tolerate. They will not last, because they have come from a different background, their expectations are greater, they do not jump around like we used to do, saying, 'Yes, sir; no, sir; yes, miss; no, miss.' For good or bad, that is not going to happen.

If we do address those issues, we should then be able to go out and say, 'This is an important profession; this is a worthwhile career.' We hear so much about the negatives of shiftwork, washing bottoms, emptying bedpans et cetera and we do not talk about the fact that we can move all over the world, we can take jobs in research, in education, in policy development, in government—in anything you like—as a nurse. We do not have to leave our profession to do almost anything. I think that needs to be promoted, but I think we have to sort out our house first.

CHAIR—Be a nurse and travel the world. When you say you are Scottish trained, do we distinguish between parts of Scotland?

Ms Laverty—We do. I trained in Edinburgh.

CHAIR—Edinburgh has got a great history of nursing and medicine, has it not?

Ms Laverty—It has indeed.

CHAIR—Is Tasmania looking at trialling or introducing nurse practitioners?

Ms Laverty—It is. We have a working group made up of the university, the board and the agency—the principal nurse adviser in particular. We would certainly like to promote the role of the practitioner. Again, we would like to see that nurse prepared at masters level; that is our ultimate aim. However, I would strongly urge the recognition of prior learning and experience in the field, so a grandfather clause to capture nurses of today's era would be paramount. In the future, we would be looking for it to be a nurse prepared at masters level. Here, it is talked about predominantly as a rural and remote role, particularly addressing the issue of the shortage of medical practitioners in those areas. The board sees it as a much broader role, a real growth role for the clinical nurse, and a very important one.

CHAIR—Ms Laverty, thank you very much. We have gone a little over time and I apologise to our incoming witnesses, but it is extremely useful information for us. If there is anything further, would we be able to contact you?

Ms Laverty—Certainly.

CHAIR—And if there is anything that you are busting to tell us, feel free to contact us. Also, with respect to the information I have asked you for, we do not expect it to be a PhD thesis. The information is a help but we do not want to give you piles of work.

Ms Laverty—That is fine. I will be happy to do it.

CHAIR—Information about the structure of the board and the kind of things you cover would be particularly useful.

[12.35 p.m.]

FARRELL, Dr Gerald, Head of School of Nursing, Tasmanian School of Nursing, University of Tasmania

ROBINSON, Dr Andrew Lyle, Senior Lecturer, Tasmanian School of Nursing, University of Tasmania

CHAIR—Welcome. We prefer 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 can ask to do so and the committee will give consideration to your request. We have before us your submission No. 449. Do you wish to make any alterations to that submission?

Dr Farrell—I have no changes to make to our original submission. I would like to take this opportunity, if it is appropriate, to add some additional comments.

CHAIR—Certainly. I now invite you, one or both, to make some opening statements and then field questions.

Dr Farrell—I would like to make three main points. Firstly, I would like to put before the committee the fact that nursing is an underused resource in health care. In our submission, we indicated that one of the few consistent findings in nursing research indicates that there is a direct relationship between patient outcomes and the quality of the nursing work force as measured by qualifications and grade. Therefore, increasing the numbers of enrolled nurses to meet present shortfalls is not, in our view, a sensible option. This would be disastrous because, in an effort to meet stringent fiscal constraints, nurse managers may be forced to employ more enrolled nurses with the result that fewer RNs are employed.

We need more and better qualified registered nurses, not fewer. Health care is increasing in complexity and sophistication. Those who are at the interface of patient care need better, not fewer, qualifications. The World Health Organisation recognises this. It states that nurses will be the main agents in progressing primary health care. While there will remain a role for personal care assistants or health care workers who are properly trained and regulated, these will be few compared to the numbers of registered nurses required.

There is now an urgent need to equip nurses with specialist skills in patient assessment, treatment and evaluation. While there is good evidence that nurses are effective in advanced practice roles, there has been a dearth of development of programs to enable nurses to fulfil these roles. In the community and rural settings, it is vital that nurses have these skills. Often, no other health professionals are available to service the community's needs. When appropriately trained and educated, nurses can play a vital role in delivering certain aspects of care and treatment to a standard consistent with that offered by colleagues from other disciplines. For example, locally a carefully conducted study found that health outcomes for patients with mental health problems were significantly improved when a mental health nurse saw patients compared to patients receiving the usual treatment or no treatment at all.

We would suggest that for far too long nursing has been treated as a Cinderella profession. There is no peak nursing body and nurses have traditionally not been afforded the opportunity to have a say at the policy level to influence the development of innovative care options. Indeed, nursing is the silent player at the pointy end of health care decisions. This is despite the very good evidence as indicated above that nurses can play a key role in patients' health care outcomes.

Our second point is that, in shoring up the present shortfall of registered nurses, new evidence available to the Australian Deans of Nursing indicates that, along with a need to increase the numbers of enrolments of Bachelor of Nursing students, health care agencies should focus their efforts on reducing nurse separation rates, especially for younger nurses. Only around 60 per cent of those with nursing qualifications are working as nurses by their early 30s. It would appear that it is in the first five years that the decision to stay in or leave the profession is made. Evidence indicates that quality transition programs are vital in persuading nurses to stay in nursing. Therefore, it is important that nursing education alone is not seen as the fall guy for the problems faced by the health care industry.

The National Review of Nursing Education discussion paper indicated that, within six months of graduation, graduate nurses are working confidently and competently in the clinical environment. This highlights that schools of nursing are doing a very good job in preparing students to practise in what is an increasingly complex and demanding environment. This is despite schools of nursing suffering from the funding crisis that has enveloped universities.

This brings me to our third point. University funding for clinical education is rarely enough. University vice-chancellors mainly determine funding models for schools of nursing and, like all other university schools, schools of nursing have to compete for their fair share of funding from a shrinking Commonwealth allocation. The implications of short cuts in the provision of quality clinical education for students will, we believe, be devastating.

Other concerns loom large, too. Quality clinical places for students are at a premium. There is no nationally agreed upon depth or breadth of student clinical experience. Clinical teachers are often ill prepared for their role and academic and clinical expectations often differ. The situation is particularly grave for postgraduate courses, and especially so in rural and remote regions. In places like Tasmania, the situation is particularly perilous, for even a small drop in specialist nurses can be catastrophic for patient care. Yet diseconomies of scale prevent a university from offering specialist courses without adequate student enrolments.

Present funding models for nursing in Tasmania are predicated on a ratio of 22 full-time students to one lecturer, and no provision is made for clinical supervision for postgraduate students, nor for the down time associated with travel to visit students who may be located several hours distance from the university campus. Many of our current postgraduate specialist courses are run in an ad hoc amalgam of partnership arrangements between the School of Nursing and clinical agencies.

It is vital that we clarify the relationship between the tertiary sector and the health care agencies regarding student placements and their education; otherwise we are in danger of offering courses that are long on theory and short on practice fidelity. Already there is evidence that some postgraduate distance mode courses in mental health nursing pay little or no attention

to an examination of students' ability to demonstrate practice skills. Yet with a little forethought and a relatively modest funding allocation it would be possible to run sound, clinically focused courses that are responsive to work force demands and are contextualised to local needs.

One option would be for the Department of Education, Science and Training to earmark funding for clinical education along with its grant to universities for nursing students. In this way, schools of nursing would have a secure funding base for clinical education. Alternatively, health agencies and universities could share the funding cost for clinical education. In this way, both sides would have a strong sense of ownership and responsibility for clinical education.

It should be noted that the value of maintaining courses at the local level extends beyond the ready supply of a work force. The infrastructure surrounding courses value adds to the health agency's quest for achieving best practice and provides a range of career and staff development opportunities for academic and clinical staff, including the development of research skills—a vital ingredient if nursing is to pursue academic and clinical excellence. In conclusion, there is a great deal of concern within the profession that we are being reviewed but that, once again, we will not be listened to. We hope that this committee will take on board the issues that it hears and address them in a way that sustains and strengthens the nursing work force for the future health of all Australians.

CHAIR—Thank you. Dr Robinson, at this time do you wish to make any further comments?

Dr Robinson—No.

Senator TCHEN—Dr Farrell, you actually make my task more difficult. I was reading through your written submission, and that raised a number of questions in my mind which I was going to ask you to clarify, yet after listening to your oral submission I notice that it is not quite coming at the same angle as your written submission.

Dr Farrell—No.

Senator TCHEN—I am not quite sure whether I should take that into account and ask my original questions. For example, one of the recommendations you listed is 'that nursing education remains located within universities', yet in your opening statement you talk about integration into workplaces. Obviously you are talking about education extended beyond university. Can you comment on that?

Dr Farrell—Indeed, I could. I think it is vital that we have a strong partnership arrangement with the health industry, especially in relation to clinical education. We need good quality clinical places for students. Our students need good quality supervision as well. Most of that will be provided from staff within the health agency, but I firmly believe that it should remain a university based course. I think now we have some good evidence to suggest that we are not doing a particularly bad job. If you look at the comment made in the recent discussion paper released by the inquiry into nursing education, the evidence indicated—

CHAIR—Dr Farrell, I think it is only the meaning of the word 'within'.

Senator TCHEN—Yes.

CHAIR—That is to say that you do not have to have a university education confined to the university site. You can have a university education off campus.

Dr Farrell—I am sure it could be possible. I would be wary—

CHAIR—Medicine has been doing it for years.

Dr Farrell—I would suggest, too, that medicine is still located firmly within the university structure, and there are all the advantages that that has as well.

CHAIR—Every other discipline knows it is, especially when it gets the money at tertiary allocation times. But a lot of the teaching is actually done in hospital—that is all I am saying.

Dr Farrell—Yes.

CHAIR—It is clear that medicine is a university course. It is clear that everyone wants nursing to be a university course, but that does not mean that the teaching has to be confined to on campus.

Dr Farrell—I would suggest that a lot of our teaching is done at the site currently. We would welcome opportunities—

CHAIR—At the site meaning?

Dr Farrell—At the hospital and in the community.

CHAIR—Off campus?

Dr Farrell—Yes, certainly. We would welcome the opportunity to extend that. The reality for us is that, the more students we put out for an increased period, we have to guarantee suitable clinical places for them.

Senator TCHEN—In that case, jumping ahead a little bit, is the University of Tasmania looking into this idea of preceptor nurses located in hospitals? Ms Laverty was talking about that earlier as well.

CHAIR—Preceptors.

Senator TCHEN—Yes, preceptors.

Dr Farrell—There has been a recent enterprise bargaining agreement whereby people, to get the extra allowance for preceptoring students, will have to have done a particular course. We are looking at that together with the principal nursing board and the university.

Senator TCHEN—It is just that earlier evidence given to us—when it was first mentioned to us today—was that, in fact, the preceptors are located in hospitals but actually work with the university. Has the University of Tasmania actually looked into that aspect?

Dr Farrell—Yes. We have a number of what we call conjoint appointments, where the salary may be met both by the health department and by us and they cross over between the two agencies. We would be very happy to extend that.

Senator TCHEN—So in that case when you are arguing that the Commonwealth should increase funding to enable a nursing degree—the School of Nursing offers a four-year undergraduate program—are you thinking that the later years will be done in hospitals on site or that it could be done straight at universities?

Dr Farrell—It could be a mixture. I am certainly aware, and I think my colleagues interstate in nursing are aware, that, in order to provide nurses with a truly comprehensive course, it is difficult to get all the specialties in the three years. Therefore, if we had a fourth year, we may be able to increase the nurse's experience, for example, in mental health nursing, community or specialist areas. Currently, it is impossible to give nurses very wide experience in relation to the different disciplines within nursing.

Senator TCHEN—It would be even more important to integrate such a course into the practical areas.

Dr Farrell—You would have to ensure that there would be an appropriate theoretical component to inform their practice as well.

Senator TCHEN—Is there much support for this proposal of extending the four years?

Dr Farrell—Certainly, I think there would be support within our school. The alternative to the four years is to have a very coherent and articulate course graduate structure which leads on from the three-year comprehensive course. Some people may go that route. We would be happy to go with either.

Senator TCHEN—So you are actually talking about a co-existence of a three-year and a four-year course?

Dr Farrell—Ideally, we would have a four-year course.

Senator TCHEN—Have you canvassed this idea widely? Is this an idea that is very current amongst the profession?

Dr Farrell—I would say that it is current amongst some of my colleagues in the profession, perhaps not all.

Senator TCHEN—Again, because that has something to do with the national standard.

Dr Farrell—Yes, indeed.

Senator TCHEN—In your written submission less related to funding, you suggest that, to enable regional schools to have staggered graduation of students, additional funding has to be

provided. Firstly, why should there be a staggering of graduation and, secondly, why would it cost more?

Dr Farrell—In terms of staggering of graduation, that would certainly fit in with work force needs in this state where, traditionally come June or July, there are approximately 30 vacancies for staff. We graduate virtually all of our students in December-January. If they do not get a job fairly quickly, they move interstate. So come midyear, there are no graduates available to fill the vacancies. That is a real issue for Tasmania and I suspect that it is an issue interstate as well.

Senator TCHEN—That would be a problem in any profession. There would be a new crop of graduates coming on at the beginning of the year in every profession.

Dr Farrell—Yes, it probably is.

Senator TCHEN—If you staggered the graduation, why would it require additional funding?

Dr Farrell—Because we would have to teach in the summer period. We would have to employ extra staff to do it.

Senator TCHEN—Surely the university staff are employed on a full-time basis.

Dr Farrell—Yes, but they would need holidays. Holidays are traditionally taken in the long break.

CHAIR—For how long?

Dr Farrell—Approximately four weeks.

CHAIR—But the academic year for teachers is about 26 weeks, is it not?

Dr Farrell—It is probably a bit more than that in terms of tidying up following exams et cetera. The semesters are 13 weeks. Then you have a break, then you have an examination period and then you have got marking time. It is considerably longer in reality.

CHAIR—Not for the students.

Dr Farrell—Not for the students, no.

CHAIR—And not for access to clinical experience.

Dr Farrell—Not for access to clinical experience, but we would also have a theoretical component. We would also have to employ people to supervise them in the clinical environment.

Dr Robinson—It comes down in part to the role of an academic. Is it just to teach when students are on campus? That is not the case. It is a multifaceted role that involves teaching, research, and professional and community service. It is a common misconception—certainly

among people whom I know—that after 26 weeks I just sit around for the rest of the year. That is certainly not the case. If you are running another semester, so that you can retain your students within a regional area and they do not leave to go to the big cities—and you want to try to stagger your graduations to account for that—you have to teach another semester. To do that you require the additional resources to teach that semester.

Senator TCHEN—My question is not meant to be a criticism as such. I am trying to bend my mind around this problem. It seemed to me logical that, if you are seeking to stagger your output, you should respond to it by staggering your input as well, so you can stagger your teaching resources in line with the staggered graduation. Could you do that?

Dr Farrell—It is possible from the point that my colleague made. You are then focusing the academic's work entirely on the teaching, and neglecting an important aspect of research and community service, university service and committee work.

CHAIR—All that is true. But if you took Dr Tchen's comments, it could be sensible that you take an intake of students in January and another intake in June and you just have the same academic year starting six months later. That is going to work, isn't it?

Dr Farrell—It is certainly possible, but then you would have to probably employ more teachers because you would be double teaching them some units.

CHAIR—Well done, Dr Farrell. Thank you.

Senator TCHEN—When you come down with detail, you suggest particularly seed funding for the development of online learning for regional schools. Can you give a brief overview of what would be encompassed by online learning?

Dr Farrell—I can give you a practical example from Tasmania. A couple of years ago we were conscious that it was difficult to find enough clinical places within the metropolitan region of what we call Hobart and Launceston. We wanted students to have a community and a rural and remote experience. That was virtually impossible because of having to come back to the university for classes. So we created an online unit where students can access the theoretical component—particularly in relation to professional issues and legal issues and ethical issues—through online tutorials and online work. They then can have the clinical place virtually anywhere off campus.

Senator TCHEN—So you are talking about regional students rather than regional schools. It sounds as though you want to set up a series of regional schools which are actually online learning centres.

Dr Farrell—No, it just provides an opportunity to accept students.

Senator TCHEN—What level of funding would you be requiring to implement those sorts of proposals? I am not asking you to specify how many millions or something, just approximately what sort of thing?

Dr Farrell—I do not think it would cost a huge amount. It might be tens of thousands really to get a small unit up of the appropriate quality.

Senator TCHEN—Can you also expand on your recommendation concerning a bonded rural nursing scholarship scheme?

Dr Farrell—Our thoughts are really that, if students were offered a scholarship, they would then give an undertaking to work within the particular area for a year or two years after graduation.

CHAIR—Have nurses ever done this before, or has it been only teachers?

Dr Farrell—I think some private hospitals are beginning to look at that now.

CHAIR—It has been mainly in the teaching profession in the past situation, hasn't it?

Dr Farrell—Yes.

Dr Robinson—We have proposals now coming forward from industry to that effect, offering students bonded scholarships, and that is just a recent development.

Senator TCHEN—You said that one recommendation is that no additional graduate nursing places be funded until an appropriate analysis of present and likely future workplace shortages is undertaken. It seems to me that there might be two problems with that. Firstly, a lot of people might disagree with you that no addition should be funded until that has been done. Secondly, how long would that take?

Dr Farrell—In relation to the first point you make, you are quite right. I think we now have some good quality information, certainly emanating from the deans of nursing. Hence my point in my verbal submission that there probably is a need to increase the enrolments of graduates. But that should not be the only thing that we should look at. We should seriously consider looking at ways to keep the younger nurses in nursing, particularly up to the age of 30 to 35. That is where the separation rates are highest. If you are 40 or so, you tend to stay.

Senator TCHEN—I have one last question, Dr Farrell and Dr Robinson. You say in your opening paragraph:

> ... that the government will not achieve any lasting improvements unless it devotes considerably more funding to the public health system.

How much more?

Dr Farrell—How long is a piece of string? I do not think you have to work for Finance or Treasury to realise that our colleagues in the health care setting are suffering, like we are in the universities, from a funding crisis. It is often difficult for them to be as helpful as they would wish to be in terms of progressing causes. I would like to put on record that we have got very good relationships with our colleagues in the clinical area in Tasmania and certainly we have been running a number of postgraduate courses. But, as I said, it is ad hoc. The funding for

them could be withdrawn at any minute when other needs arise. So it is not secure. It is not recurrent. In the same way as we get funding from the university department of rural health to assist students to work in the rural areas, again, we have to make a case on a yearly basis for that. It is in no way sustainable.

Senator TCHEN—They are the characteristics of a government trying to respond to a changing condition, are they not?

Dr Farrell—Sure.

Senator TCHEN—To changing demand and changing priority?

Dr Farrell—Yes. I would suggest that we are suffering as a result.

Senator TCHEN—Thank you, Dr Farrell.

CHAIR—The last question that Senator Tchen asked was one that I wanted to ask.

Senator TCHEN—I am sorry.

CHAIR—I think you should take a bow, because it is quite curious. Here you are campaigning for all sorts of things and, suddenly, no extra places: really! I have never met an academic who did not ask to increase his empire. I am very pleased to meet you, Dr Farrell.

Dr Farrell—Could I respond to that? I think, to date, most of the arguments for an increase or a decrease, or whatever, have been based on anecdotal evidence. We really do not have hard evidence to support our case. I think we are beginning to get some through now. As I mentioned, the Australian Deans of Nursing have got some evidence in relation to separation rates. So I suggest that in a few months we probably do need to be increasing the enrolments.

CHAIR—Yes, and I think it would be better if you wrote this dot point as ‘the case for additional undergraduate places’ et cetera. To just baldly say ‘none would be given until’ is a very brave academic claim. What is external commitment? Do you mean clinical experience outside of the university?

Dr Farrell—No, I mean external commitment in relation to government commitment, funding for the health service to allow appropriate clinical places to occur.

CHAIR—You said:

The external commitment to nursing through strategic collaborative partnerships must be strengthened.

Do you mean government funding?

Dr Farrell—Yes, government funding would go a long way and also—

CHAIR—And what do you mean by the words 'external commitment'? I simply do not understand what is meant.

Dr Farrell—External commitment from the government means to have a degree of concert in relation to our responsibility particularly for clinical education.

CHAIR—I understand 'collaborative partnerships'. What is meant by 'external commitment'? You said:

... there are four main areas that must be addressed:

- Nurses must feel themselves to be part of a valued and united profession.
- Nurses must have a strong educational preparation ...
- Active retention measures must be set in place.
- The external commitment to nursing ...

Do you mean by the community, by the government, by the hospitals?

Dr Farrell—No. I would suggest from the government.

CHAIR—I just like to know what it is I am reading. I am open to misunderstanding by mistake. On page 7 of your submission, you tell us:

The advent of two inquiries into nursing has led to speculation that the Government intends to transfer undergraduate nursing education to the TAFE sector ...

Where does such speculation come from?

Dr Farrell—Simply from my colleagues, both within industry and within academia.

CHAIR—This is actually called a suspicion amongst academics, that they are about to be deleted from university?

Dr Farrell—Yes, and from colleagues within the industry as well, I would contend.

CHAIR—What evidence is there that they will be putting it to TAFE?

Dr Farrell—I do not have specific evidence.

CHAIR—This is just a wonderful sentence of paranoia, is it?

Dr Farrell—I would not go as far as that; it has been mooted.

CHAIR—'It has been mooted'; thank you very much.

Dr Robinson—Can I make a comment in relation to that?

CHAIR—Please, Dr Robinson, make me a bit more reliable and responsible here, yes.

Dr Robinson—If we look at the deskilling of the nursing work force—and the deskilling that is rampant within health care, particularly within aged care, where we have unregulated workers now increasingly providing care—that has an increasing economic imperative underpinning that sort of development. It is certainly not to do with quality care; it is certainly not to do with improving the standard of care; it is to do with actually keeping the bottom line down that is reasonable. It is not unreasonable to think that a government that has two inquiries into nursing concurrently—

CHAIR—Which two?

Dr Robinson—There are two inquiries. One was from the previous minister, and one was from the Senate.

CHAIR—The Senate one is because the previous minister would not do it, and he did not do it until we started. We are very disappointed that we might, in some way, be contributing to a great anxiety amongst the nursing profession. Let me tell you that—and you can pass it on to your colleagues—as the minister was dragging the chain on having an inquiry into the needs for nursing, the Senate acted.

Senator TCHEN—I am not even aware that the previous minister has started the inquiry.

CHAIR—Yes, it is well under way. I am sorry if that has contributed to a misunderstanding. I am on the record as having said that, so I might be shot in the head by somebody. I have not seen that anywhere else and, as far as I know, I have not picked it up in any other submission. I am very interested to note it. I do know that every witness we have seen and every recommendation says: nurse education should remain within universities. I do not think there is much dispute about that. It may well be that what are called types of nursing might be moved to TAFE, like the ENs and more. I do not have any sense that there is a drive to push nurses out of universities, and I understand that there would be a brawl a mile wide if they did.

What we do have to deal with is the balance between university and clinical experience and the notion that much of the university education could be provided in the clinical setting. I would be interested for you to talk about that a little, because we have been told that one of the major restrictions, for example, to the number of nurses getting places is that there is not access to quality clinical experience. Forget about whether or not there is even a preceptor or a tutor—an old-fashioned word—to look after them, there is just not the clinical experience. One of the things that you were partly answering, in terms of answers to questions from Senator Tchen, is the academic year being 26 to 30 weeks in terms of contact time. That is, therefore, a restriction on the access to clinical experience because there are all those other weeks when patients are still in institutions and the community needs nursing care. The clinical experience could be a much longer experience per year. How would the university offer to address that?

Dr Farrell—We would certainly have to offer in partnership with our colleagues from the health industry. The danger is that, if you extend the period, the students may not get the quality supervision that they formerly had in getting a shorter experience. So we would have to—

CHAIR—It is mainly clinical supervision?

Dr Farrell—Yes.

CHAIR—That is an important point. I would welcome your assistance here. At what rate do you parallel the theoretical input and clinical experience?

Dr Farrell—I am sorry. I am not sure I am following the question.

CHAIR—One of the claims about why nurse education should be in universities is that it is now a profession of such complexity and seriousness that there is absolutely a need for a proper theoretical underpinning. That is a shorthand way of saying all the sorts of things you learn about what is required in nursing. No-one wants to retreat from that but can you get your theoretical education for year 2 in the first six months of the academic year and then do clinical experience for the next six months? Is it necessary in your view to have three months of clinical experience and then a month of theoretical?

Dr Farrell—There is no easy answer to what you are posing. Academics have been discussing similar comments for some time. I would suggest that this would be an ideal opportunity for the Commonwealth to set up some pilot schemes around the country looking at different models, integrating theoretical and practical experience to see what the outcomes are.

CHAIR—But we do know at the moment according to evidence that the current practices are grossly insufficient. One of the reasons nurses are walking out of nursing is that in their first year out of college, when they get full time into the wards they are, to quote, gobsmacked. They have not really got a sense of exactly what is required of them. All the theory in the world is not going to help if you just cannot cope in the clinical setting. We do not need to go to the model that we have currently got. By any evidence it is insufficient. Other places are moving to increasing the amount of clinical time. That would be a help. I would like to know if you could talk to me about the weaving of the theory with the clinical experience when they might be happening at separate places.

Dr Robinson—You can have an applied model where you say, 'Open up your mouth and I am going to pour in all this stuff. Then we are going to have you go out there and have you apply it.' That is fairly bankrupt educationally and it does not really work because the knowledge that you gained is not necessarily applicable to the context in which you are wanting to apply it or the process of application eludes you. You cannot apply it. You cannot make the links between what you know and what you have got to do. What we need is an integrated model where we have students in practice. They then have the possibility and opportunity to actually engage with what it is they are doing in practice, the issues around what they are doing and how they are going about that and what are the key points, concerns or knowledge that they need to have to actually be effective. We have run that sort of program and that has been very effective with our graduates. It has been highly efficient. In other words, our focus has not necessarily been on trying to teach them about everything. It has been trying to teach them the skills and knowledge that they need to be competent registered nurses and how to identify issues and knowledge gaps and then fill those gaps.

CHAIR—As a first-year registered nurse student at the University of Tasmania, how much clinical experience am I going to get this year?

Dr Farrell—Extremely little.

CHAIR—What does ‘extremely little’ mean?

Dr Farrell—Virtually none.

CHAIR—What is virtually none? Am I going to a hospital at all? Am I going to an institution anywhere?

Dr Farrell—No, you are certainly not going to a hospital. You may go out and do some community service and engage with former patients.

CHAIR—On evidence all around Australia, that is a formula for wastage.

Dr Farrell—Certainly next year we are looking to put first-year students into the practice arena.

CHAIR—Why, Dr Farrell?

Dr Farrell—Following our accreditation with the Nursing Board of Tasmania that was one of the recommendations. We are happy to take up that challenge to put 200 extra students into the clinical environment in year one.

CHAIR—For how much time?

Dr Farrell—The recommendation was for two weeks.

CHAIR—Only two weeks?

Dr Farrell—Yes. I came through the hospital training system and I can say that the attrition rates there were particularly high as well.

CHAIR—That is a very important point. If you have any evidence for us I would very much welcome that. Others have said the same. It is all very well to say that this system does not work and there is a big attrition rate. But there was a very big attrition rate before. We need comparable data. Before, as a hospital trained nurse you would work all day on the ward and then repair to the lecture theatre where some nurse educator—which is a euphemism for what many of them were—would proceed to rearrange your brain about what you had just been doing.

For a lot of people it was fantastic because it was exactly like what you said—teaching where the theory matched very much what they were doing in their practical experience. It did mean that the nurses were working full time and then adding study, which was extremely demanding. It also meant that the capacity for full theoretical education in the nursing arena was very re-

stricted. Everyone has agreed it has to change, but everyone seems to be saying the formula is out of whack. We have now got people doing so much theory that they have not got enough smell of what the clinical experience is. Dr Farrell, what is your feeling about two weeks in a year?

Dr Farrell—I have taken soundings from people who are running graduate programs. When students graduate, they often have six months or a year in a professional development year—

CHAIR—I do not even know yet whether I want to be a nurse, Dr Farrell. Don’t tell me what I can do when I am a graduate. I want to know right now.

Dr Farrell—Our attrition rates are probably similar to other schools of nursing. Our experience from talking to people running the graduate programs is that our students are functioning at a very high level soon after graduation.

CHAIR—Indeed, so why are you adding two weeks experience in the first year?

Dr Farrell—That was the recommendation from the review panel.

CHAIR—You don’t want to do it?

Dr Farrell—Yes, we will do it.

CHAIR—That is right. I am trying to find out whether you can tell me that you are absolutely sure that this need to get into the clinical thing is going to make for better nursing, and make your theory better taught to the students. Are you interested in that end of it or are you just looking at the theoretical input?

Dr Farrell—No, we are looking at both. I should say that at our school we have already got clinical divisions located in the hospitals where we employ our own academic staff plus clinical teachers. We have them based at Royal Hobart Hospital, up at Launceston General Hospital and up in the north-west at Burnie Hospital.

CHAIR—If I want to be a nurse student from Hobart do I actually have to go and live in Launceston?

Dr Farrell—You would do certainly for the first year, although that will change next year because we hope to be able to allow Hobart based students to do their clinical practicum in the area from where they come. They can do quite a bit of the second year out of Hobart and they can do all of the third year out of Hobart.

CHAIR—Can you just tell me a little bit more about that? In second year, what are the nurses doing? Is it mainly clinical experience?

Dr Farrell—Clinical experience and theoretical experience as well.

CHAIR—But mainly based around the hospital?

Dr Farrell—Hospital and community.

CHAIR—So if I was doing community nursing experience in second year in Hobart, where would I go for my university teaching?

Dr Farrell—You might go to one of the community centres for three weeks. You may go to work with a community nurse.

CHAIR—No, where am I going to get my university teaching—not my clinical experience?

Dr Farrell—The university teaching would be done at Launceston campus and then you would go off campus for your clinical experience and have that supervised on site.

CHAIR—And then I have to keep going back to Launceston.

Dr Farrell—No. You would have a block of three weeks at least in clinical practice. We bring that in during week 11, 12 and 13, then you can finish.

CHAIR—Then what do I do?

Dr Farrell—For second semester you would come back to Launceston for a similar period of theoretical followed by practice towards the end of the semester.

CHAIR—I am very fond of Tasmania but that sounds like the rattiest way to educate people I have heard of in a long time. What do they do? Do they go and live in a hotel or motel for four weeks while they do their course?

Dr Farrell—It is certainly a concern for us.

CHAIR—I can imagine.

Dr Farrell—I would love to be able to offer the same opportunities for students in the south as in the north.

CHAIR—What would be required for you to do that?

Dr Farrell—Resources would be required because obviously we would have to do the same teaching for two groups rather than one.

CHAIR—Sure, so we need a couple of lecturers and whatever, but what else do we need? Do we need large facilities? Can you use other lecture theatres? I think it would be very useful if you could tell me roughly, on notice, what would be needed.

Dr Farrell—Yes, indeed.

CHAIR—Certainly, I think it is a very strange arrangement.

Dr Robinson—The students will go and locate in Launceston in second year; those students who will go to Hobart, by and large, have families living in Hobart. So we have students from all over the state. Those who go up into the north-west coast will, by and large, come from the north-west coast. The students self-select as much as possible so that they are not in a doss house or something like that. The other thing that must be understood is that in third year it is all practice within our curriculum. So they are in practice for the entire academic year, supported by online units or units that are taught out of the clinical sites.

CHAIR—How many of your students drop out in second year when they hit the clinical situation?

Dr Farrell—The attrition goes down considerably in second year. I do not have the figures to hand but I would suggest that it is less than 10 per cent.

CHAIR—I must say that a third-year full clinical experience year certainly sounds different from other places, where even in third year students were getting very small blocks of clinical experience. Have you done any comparison/contrast of your program of nurse education and clinical/theoretical to any on the mainland?

Dr Farrell—Only anecdotally. We know, as you suggest, that the third year is quite different in other schools, and their second year. There is some common sequence of experience or theoretical instruction for the Bachelor of Nursing courses across Australia.

CHAIR—Has the course changed much in Tasmania since it was started?

Dr Farrell—I would suggest that it has changed considerably.

CHAIR—From what to what? That is from less clinical experience to more, for example?

Dr Farrell—Clinical experience with the last review has increased. The main changes would be within the theoretical component, I would suggest, and ensuring that the course's theoretical component is relevant to the needs of nurses.

CHAIR—Are there any papers you could refer us to that compare the nurse education undergraduate program for an RN between the institutions?

Dr Farrell—No. I cannot think of any papers. We did some research a few years ago looking at the amount of mental health experience that nurses get in undergraduate courses across Australia. That was markedly different, and I could give you that paper if it would help.

CHAIR—That would be useful; thank you very much. If you moved to what you propose, which is a suggested fourth year, would that be a repeat of third year or would it take a rearrangement of the whole course?

Dr Robinson—That would require us to rearrange the whole course, at least the third and fourth year. We have an honours program, which is a fourth year now, and it is a thriving honours program. You might make an honours stream over those two years. You might then

make a mental health stream, a community stream and an acute stream. So you would have to reorganise the third and fourth year, which would require significant change.

Dr Farrell—Obviously, we would have to have the imprimatur of the Nursing Board of Tasmania as well.

Dr Robinson—And the funding to effectively mount that. With respect to clinical experience, it is a very vexed issue as to how to teach nurses in practice. I have had a lot of experience working for many years as an educator in the Royal Children's Hospital in Melbourne, and then working here with students in practice out of a clinical school, so being based in a hospital, working for a university, teaching university students. It is a very complex business. It is not necessarily the time alone. I was one of the very first diplomates in this country, in one of the very first groups, in the late 1970s.

CHAIR—What were you?

Dr Robinson—I got a diploma of nursing.

CHAIR—A diplomate? We have a different understanding of what a 'diplomat' is. There are no qualifications at all!

Dr Robinson—Not in the diplomatic corps, unfortunately. I got a Diploma of Applied Science in Nursing in one of the very first schools. The attrition rates were enormous because we were dumped into practice. We did six weeks preparation and then we were put in there. So many people left—it was just crazy—because they were overwhelmed.

CHAIR—Things are better now, you are telling me. But what is the challenge for you that you just described in terms of saying, 'I now teach in a clinical situation but I'm teaching the academic theoretical input to those people in and around their clinical work'?

Dr Robinson—The challenge is to give the students a positive learning experience in an environment in which it is increasingly difficult to do that. The challenge is when nurses are highly stressed, very busy, where turnovers are very high, where patients are much sicker, where the opportunity to provide mentorship and support to students is far more limited. That is the difficulty—where students are abandoned.

CHAIR—Why are they more stressed? Is that because of the reduction in staff?

Dr Robinson—The whole nature of health care has radically altered in the last 10 years. You just have to look at the occupancy rates in hospitals, the turnover rates and at all of the statistics from the Australian Institute of Health and Welfare. The figures demonstrate that we have fewer beds with more people who stay for less time and who go into the community much sicker. So all of that adds to the complexity of workload requirements. At the same time, we have not seen an increase in the number of nurses. So these people have got more complex work to do in less time with fewer people. When you add students into the mix, it is very hard to create a creative and positive environment to facilitate teaching and learning. You can do that but you need to support not only students but also the nurses who work with the students primarily.

CHAIR—We have run out of time, unfortunately. This has been an extremely important and very useful contribution. I wanted to ask you a bit about research. I know that, amongst other things, nursing is under pressure from everybody else in the university who regards you as last on and probably easy off, if not first off. Can I ask you to take on notice and give us a brief piece of paper. I do not want a thesis; some dot points would be fine because I understand that you are very busy.

I would like you to tell me about the importance of research, the capacity to do it and what kinds of things it covers. I know that universities are finally recognising the importance of teaching, so that people can actually be promoted in universities because they are good teachers rather than the producers of 25 papers. We probably need a balance between both, but I would be interested to hear how the nursing profession is addressing that academic type challenge, apart from all the other things that you have just raised, Dr Robinson, which are very important.

If there was anything further that you can tell us regarding how you are planning to work that out, that would be helpful. I would like to know about the research and how much of it might be theoretical research and how much of it might be really important applied research. I would be appreciative of that, as well as anything you have got to add about evidence based medicine and evidence based nurse practice.

Finally, you recommend that the Commonwealth waives HECS for postgraduate nursing studies. I would like to be clear on this because I would have thought that the one thing that would help people to do postgraduate studies would be HECS. If you want to say 'to waive fees', that is one thing. But you have said 'to waive HECS', which means that they have to pay up front.

Dr Farrell—I am sorry. What was meant was to eliminate fees altogether.

CHAIR—Thank you. What would be your response to keeping HECS so that postgraduate students did not have to find $10,000 up front?

Dr Farrell—I would prefer that you keep HECS. But I think there has to be an incentive for students to do the specialist courses. Currently, I do not think they are being rewarded when they do the courses. So that is compounding.

CHAIR—That is a very important point. We have also had evidence that you may get postgraduate qualifications but they may not lead to an increase in salary. We have gone past time, and I am sorry about that. This discussion really has been very useful. If it sounded a bit like the devil's advocate, it was very important for us to really push to get those answers.

The one thing that is a consistent message across Australia is that university education will be where nurse education stays. It has been a very awkward time for people to start saying that we need to get back into hospitals more. From what you are saying, and certainly from what others have been saying, the challenge is to do that: to stay with a university course but to increase the clinical experience. How you actually put those two together is the crunch. What I have picked up is that it is not a retreat from universities; it is a question of getting the balance right. If you have anything further to tell us, please feel free to drop us some points. Thank you very much indeed.

Dr Farrell—Thank you.

Proceedings suspended from 1.31 p.m. to 2.11 p.m.

BINGHAM, Mrs Sharon, Vice President/Secretary, Tasmanian Operating Room Nurses

TAYLOR, Miss Helen Margaret McArthur, President, Tasmanian Operating Room Nurses

GRAHAM, Ms Linda Anne, Community Mental Health Nurses

POLANOWSKI, Mrs Vicki Denise, Community Mental Health Nurses

PEARSON, Mr Jim, State Councillor, Australian and New Zealand College of Mental Health Nurses

POLLARD, Miss Cecily, State President, Australian and New Zealand College of Mental Health Nurses

WALLACE, Ms Carolyn, Member, Aged and Community Care Services, Tasmania

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 will give consideration to your request. The committee has before it your submissions Nos 775, 264, 108 and 327. As no-one wishes to make alterations to those submissions, I ask you to make an opening statement and then field questions from the senators. We will do it as a panel. We wanted to get as many witnesses as we could. If we were to take you seriatim, it would have taken longer. I very much appreciate your cooperation in this. Shall we start with Ms Wallace?

Ms Wallace—I am speaking on behalf of Aged and Community Services, Tasmania. I am really speaking from the aged care nursing perspective only. Approximately 30 per cent of nurses in this state are employed in the aged care sector. The submission refers to the main issues affecting aged care nurses, which relate to the retention and recruitment of aged care nurses. There are some particular issues revolving around that. They include the scope of practice of nurses in aged care, which has greatly expanded. What in the past was the usual or expected level of practice for registered nurses in aged care has actually become greatly amplified.

This expanded practice is now considered the norm. There is actually little formal educational support for that. Currently postgraduate gerontological courses are not available in this state. The aged care sector is not included in the undergraduate program. Some pilot programs commenced this academic year and there is a small group working with the University of Tasmania to expand greatly the undergraduate placement in aged care but that group only started late last academic year.

Some of the other issues revolving around retaining and recruiting nurses to aged care are in a survey that was conducted in 2000—it is mentioned in the submission. Some factors that came out of that reveal that the average age of Tasmanian aged care nurses is nearly 48 years. The average age for director of nursing is actually 52 and the vast majority of nurses appear to retire

around 55 years of age. So, in 10 years time, there will be a very sorry picture should that trend and the lack of educational opportunities continue. The most significant issues for the projected work force relate to the decline in the number of nurses in aged care nursing. In the overall nursing work force for the period 1993 to 1999, 5.5 per cent of the nursing work force decreased. In aged care, the figure was actually 8.2 per cent and that would appear—

CHAIR—Over what period, Ms Wallace?

Ms Wallace—From 1993 to 1999.

CHAIR—From 1993 to 1999, the nursing work force went down—

Ms Wallace—It was 5.5 per cent for the overall work force and 8.2 per cent in aged care—that was from the DST study. During that time, there was also an increase in undersupply of what in this state we call extended care assistants. Other states call them personal care assistants, assistants in nursing—that is, the unregulated or trade certificate level that provides the personal care. Another issue for aged care is that there is a significant wage disparity. Currently in this state it is 10 per cent on the public acute sector that aged care is below. The private acute sector has various enterprise agreements, which actually widen that gap.

CHAIR—Is that for every level of care providers in the aged care sector—RNs, ENs and extended care assistants?

Ms Wallace—Just RNs and ENs. In the extended care assistant level, there are very few of those in sectors other than perhaps the disability sector.

CHAIR—Thank you.

Ms Wallace—That is a big issue and, in the current mechanism for funding aged care provision, there is no allowance to address that wage disparity. The other issue concerns the excessive amount of documentation, but I am not sure that this is the place to launch into that.

CHAIR—It is a point that has been raised with us every time, and it certainly is appropriate to put that comment here. I can assure you everyone else has.

Ms Wallace—As you are probably aware, the level of documentation required to support the Department of Health and Ageing's funding of aged care is far in excess of the documentation required for other normal professional nursing documentation. We are more than happy—which is probably not the right word—to use normal professional standard nursing documentation.

The RCS funding tool does require a much higher level. A brief survey conducted earlier this year of Tasmanian aged care providers, which looked at about 25 per cent of aged care providers, found that there was probably an extra $4 million of time spent completing just the RCS requirements in excess of normal documentation requirements. This time could have been better spent perhaps in providing direct resident care. The Aged and Community Services submission of February 2000 to Treasury for consideration in the budget development process has a lot more detail on ways to streamline that issue and bring it more into line with normal professional nursing level documentation.

Another issue that is attached to aged care nursing is the extra supervision that is a requirement imposed on the registered nurse because of the very large numbers of non-professional or, as they are called in some places, unregulated care assistants. That does not occur as widely in other spheres. The rationalisation of a lot of support services has meant that RNs are doing a lot of these clerical, human resource type things and a lot more management functions than perhaps they may in another sector where the supports are not there.

Another issue is the increase in consumer and community expectations of the services that aged care will provide through the growing awareness of recent times—what you can expect, or what the community feel they have a right to expect, in aged care facilities. The funding to provide those services is not always there. There is a big increase in the acuity of people who are entering or receiving aged care services. Nationally at the end of June there was just over 140,000 people in residential aged care, and over 60 per cent of those were high-level care.

Another issue for Tasmania is the fact that Hobart, in the scheme of things, is the only area designated as metropolitan for funding services, but in fact Hobart has a lot of the issues associated with being rural and remote. The rest of the state is rural and remote. The Productivity Commission submission into the funding equalisation issues demonstrated that the whole of the state perhaps could be classed as rural and remote. It has a larger aged population ratio than many other states, and demographic projections indicate that it will probably continue to age at a faster rate than some other states.

The other big issue for aged care, as I have touched on before, relates to obtaining specialised gerontological nursing qualifications in this state and basically there are none at all at present.

CHAIR—I think your statement is fantastic, Ms Wallace. If there is something that you are really burning to put on the record we will come back to questions and you can certainly add it then. But we will move along and hear an opening statement from each of you and then you can expect some questions. But if there is something you really wanted to say, please just give me the call and you can put it on the record.

Miss Pollard—Thank you for the opportunity to be here. The Australian and New Zealand College of Mental Health Nurses is the only professional body representing the interests of mental health nurses and it has over 1,500 members. The Tasmanian branch, which Mr Pearson and I are representing today, has a membership of 90. The objectives of our college are to promote the professional status and public awareness of mental health nursing; to advance mental health nursing education and promote high standards of practice; to promote mental health nursing research for the benefit of clients, the profession and the community; and to represent the mental health profession. It also participates in the development of policy as it applies to mental health nursing practice.

The Tasmanian branch supports in principle the national nursing organisation's submission to this national inquiry in line with our national body's support. The Tasmanian branch is concerned about the growing shortages, the ageing of our specialised work force and the lowering of morale within our specialised work force both state and nationally. We have addressed these concerns under the headings of promotion, education and retention—retention being the one which is our greatest concern. Retention has two major headings: the perception

and reality in some settings that this area of nursing practice is violent and dangerous and discourages the beginning practitioner; and that this perception is compounded by society's difficulty in differentiating between madness and badness.

CHAIR—Succinct. Is that all? Thank you very much, Miss Pollard. Who is speaking for the Community Mental Health Nurses?

Ms Graham—I am. Thank you for the opportunity to address you regarding our concerns. We submitted a paper which only looked at point (3), the recruitment of nurses into the work force and their retention. That was the only issue we addressed. As has already been said, Vicki and I come from community mental health nursing, which follows on from Cecily's concerns. We have been gravely concerned with the situation in Tasmania, particularly when we see many nurses in other states are offered better pay and conditions. For example, other states have staff development offered, with a dedicated budget, which is not the case in Tasmania. Some of the examples that we thought might be very useful for retention and recruitment of mental health nurses are equal pay scales with other states—that is probably the major one, to equalise the pay scales—and also for the community mental health nurses to have pay parity with other disciplines that operate at the same level in the mental health area.

CHAIR—Could you give us the amount you are behind—mental health nurses in Tasmania compared to, for instance, public hospital nurses? Is there a salary difference?

Ms Graham—There is no difference in Tasmania; it is between the states.

CHAIR—How much are you behind?

Ms Graham—Eight per cent.

Mrs Polanowski—Between Tasmania and New South Wales, for example, there is roughly an eight per cent difference in pay rates.

CHAIR—What about in South Australia? New South Wales is about eight per cent ahead of the rest of the world in everything, isn't it?

Mrs Polanowski—Queensland is about five per cent more. They were just two comparisons that I looked at.

CHAIR—That is helpful. Did I misunderstand you? Did you say the wage parity between nursing within the different sections of nursing?

Ms Graham—No, it is between other disciplines. Within a community mental health centre, there are a variety of people like social workers, psychologists, community mental health nurses, all doing exactly the same tasks. What we would like to see is pay parity.

CHAIR—It is always nice to put in an ambit claim, isn't it, Ms Graham?

Ms Graham—We can but try.

CHAIR—You make a good point—if you are doing the same thing. I think it is different if people have qualifications that are different. But here in the community setting you are saying you are doing the same thing.

Ms Graham—Yes.

CHAIR—That is a good point.

Ms Graham—Exactly the same. One of the other things—this is already happening but only in a small number—is to offer funded part-time or full-time placements for postgraduate nurses who are doing the mental health postgraduate courses at the university, so that we can encourage people to do that postgraduate mental health training. We just feel that, if we can raise the profile of mental health nurses in Tasmania, we can stop being predominantly reactive and become more proactive with the care that we provide for our clients and the service we give.

CHAIR—Thank you. Our last witnesses are the Tasmanian Operating Room Nurses.

Miss Taylor—I would like to thank you for giving us the opportunity to be here. The Tasmanian Operating Room Nurses—TORN, as we call ourselves—are actually the Tasmanian branch of the Australian College of Operating Room Nurses. A lot of our issues are exactly the same as those of the other groups: retention, recruitment and also the people’s perception of what an operating room nurse is. The average age of operating room nurses in Tasmania is 45-plus. We are old, tired and working harder than ever.

We are sometimes called the last bastion of the doctors’ handmaidens, so what people see us as is not quite true. There is a genuine lack of respect for us amongst our colleagues regarding study leave et cetera. For example, we have our major conference coming up next week. We will not be given the same respect that is given to our medical colleagues who attend a conference, who have their lists postponed or curtailed so that as many members can attend as possible. That is an example of the perceptions we are finding that people have.

Our area is now technology intensive, and the equipment is not matching the technology. Well, the equipment is, but getting the equipment, especially in the public sector, is an issue that was very prevalent when I was working in the public sector a year ago, when we wrote this submission. We are reactive and crisis managing; we are not planning ahead. We know that we need to do this, and we would like to, but we are not putting into practice a program over, say, 10 years for equipment maintenance and equipment replacement. What is happening is that we are replacing after a crisis, when something breaks down. We have a lot of old equipment for which we cannot get parts any more; then we have to buy something totally new for many thousands of dollars, because the plan is not in place. It is being worked towards but it is not in place and the budget is not matching what the needs are.

The biggest problem that we have, though, is the lack of clinical support for our graduate nurses. They are coming into theatre because they think it might be an interest area. They are not given exposure to operating room nursing in their training. They might have three days where they come and watch us but that is nowhere near enough time to come and see a culture that is so different from any other in nursing. This does not allow them to appreciate what we

actually do, and it only reinforces the task orientated behaviour that is associated with operating room nursing. They are not appreciating the entire picture of a patient who is undergoing a major stress. When the nurses come out into the operating room, they are paid as a registered nurse but they cannot work as a registered nurse.

CHAIR—Say that again, please.

Miss Taylor—They are paid as a fully functional registered nurse but they are unable to function as a registered nurse in the operating room. They just do not have the necessary skills for that area.

CHAIR—In the standard, routine way, when does a person first get to an operating room?

Miss Taylor—At the moment, here in Tasmania, when they become a graduate nurse, so they are qualified.

CHAIR—So some nurses who have graduated might finish on surgical wards, some might finish on medical, some might finish in A&E and some might be in skin, and some are sent to the operating room?

Miss Taylor—They request where to go.

CHAIR—Really? Staff planning is by request?

Miss Taylor—For the new nurses, for the graduate nurses. We have so many positions in each hospital for graduate nurses in all the specialties, but basically they put down the areas they are interested in and would like to work in.

CHAIR—And if they don't get what they want?

Miss Taylor—I am not sure what they do then. They get options.

CHAIR—So some people would actually say, 'I'd like to go straight into the operating theatre from college'?

Miss Taylor—Yes.

Mrs Bingham—With no preparation.

Miss Taylor—No experience and no exposure.

CHAIR—What kind of operating theatre experience in their undergraduate degree does a student nurse get prior to graduating?

Miss Taylor—They have an elective of three days or three weeks observation, depending on where they are.

CHAIR—They have either an elective of three days or—

Miss Taylor—Or three weeks, depending on which hospital they are at. The Royal Hobart Hospital offers a three-week exposure to operating room nursing but it is an elective; they can request that or not. So they may have none.

CHAIR—Are there any precedents for a paid supervisor of first-year RNs coming into the operating room?

Miss Taylor—No.

CHAIR—So if you are the charge nurse in the operating theatre today—is that what I would call you?

Miss Taylor—No, I am a clinical nurse in the operating room. Sharon is the manager of the operating room suite.

CHAIR—I will find out about those differences later. But somebody is the head honcho?

Miss Taylor—Yes.

CHAIR—That is you?

Miss Taylor—Yes.

CHAIR—Would you have the responsibility for keeping an eye on the brand new, recently arrived nurses?

Mrs Bingham—What normally happens with the graduate program is that there is an educator who is responsible for the graduate program in that hospital. For instance, in our particular setting, we have got 16 graduates in the hospital and we have a coordinator who looks after their placements. Obviously, she cannot be with them because she cannot split herself into 16, so we rely very heavily on preceptors in each clinical area who take on that responsibility for mentoring and precepting that student during their graduate program.

CHAIR—There would be a preceptor type person in the operating room?

Mrs Bingham—Yes.

CHAIR—Keep going, Miss Taylor; I beg your pardon.

Miss Taylor—This preceptor is expected to work as closely as possible with the graduate nurse, who is also a fully functional member of the team. They are not supernumerary but they cannot work, so they are in a difficult position as they are counted in the total numbers of people that are employed in the operating room but they are unable to function in that role.

CHAIR—Let us make that clear. Who is counted as a supernumerary—not the preceptor?

Miss Taylor—The preceptor is counted and the graduate nurse is also counted.

CHAIR—And the graduate nurse is actually counted as staff, but really not yet able to do much?

Miss Taylor—No, they are unable to.

CHAIR—Thank you.

Miss Taylor—They have that position for a year, in which time they are trained.

CHAIR—How long does it take you to feel that you can let one go?

Miss Taylor—At least three months, depending on the nurse.

CHAIR—Is that the minimum?

Miss Taylor—Yes. That is just the basic level coming in. Often they split their time and they do six months in the operating room and six months on the ward. So we often lose them to the ward because they have had their exposure and decided that it really was not what they wanted to do and they move on. So we are not keeping any young nurses in the operating room, as a rule. That is a big problem for us. The majority of operating room nurses are going to retire in the next 10 years and they are not being replaced. To do an operating room course, or a perioperative nursing course, you now have to do it from Tasmania by distance education. There is not one run in the state, and that causes us quite a bit of concern because they are not getting the clinical experience that they need to be a good operating room nurse. Doing something that is so clinically based and practical by distance education is not the ideal way to run a course like this. We are not even formally training anybody any more.

CHAIR—What exactly does an operating room nurse cover? Is it pre-op and post-op?

Miss Taylor—In the recovery area, yes. It is pre-op if you are talking about the anaesthesia period where the patient is checked in, put to sleep. The surgical assisting and circulating for that team and the post-op recovery in the recovery room is all part of the operating room nurse or perioperating room role. We also have a lot of impact in day surgery because day surgery units are often part of the operating suite. We work in that area too, which does include pre-assessment and pre-admission.

CHAIR—Thank you very much. Is there anything further?

Miss Taylor—No.

CHAIR—We will leave it at that.

Senator TCHEN—Is it true right across your specialisation areas that a nurse will graduate from the university and then he or she can opt to go into any of the specialty streams?

Miss Taylor—Yes.

Ms Graham—Yes.

Senator TCHEN—They may have had some units earlier at university, but they really learn about the job on the job; is that right?

Mr Pearson—If I understand what you are saying, before people can actually work in the mental health area they need to do their general nursing qualification, which is a university qualification, a graduate year and then a two-year part-time postgraduate diploma. During that period they are having clinical experience as well.

Senator TCHEN—Is that the same in aged care?

Ms Wallace—No, you just walk in, because of the shortage. Certainly some of the larger facilities—I run the state's largest facility—will take one or two graduate nurses, if we can attract some and find some resources to mentor that person. It is not funded, and most RNs do it because they can see that, at some stage, they can turn this person into having the skills. You then require this person to have the discipline and the initiative to basically get up and go to do something by distance education, which is also quite costly.

Senator TCHEN—It is the same with the operating room nurses?

Miss Taylor—They can just front up and we will train them on the job.

Ms Graham—In Tasmania, which is slightly different, you cannot have a permanent job with mental health services unless you have qualifications in mental health.

Senator TCHEN—So mental health requires some specialised training?

Ms Graham—Yes, to have a permanent position.

Senator TCHEN—But in other areas you can just walk in and learn on the job. Is that because the university training those students is not putting enough emphasis on the clinical aspects?

Mrs Bingham—Yes, in specialty areas. It is a very broad based program in university and they only get very minimal exposure to the different specialties. For example, critical care, peri-operative care, accident and emergency care, aged care, and community nursing have very brief overviews within a three-year program.

Ms Wallace—I would like to add to that. A vast majority of the people in acute hospitals on the general wards are old. A lot of people assume that, because they have cared for somebody who is old in an acute care setting, they have a lot of experience in aged care. But residential aged care is quite different to caring for someone who is in an acute hospital who is also old.

Senator TCHEN—You have a very large management aspect as well.

Ms Wallace—There are different things that someone in residential aged care who is not acutely ill needs. That knowledge can only really be acquired through a proper tertiary postgraduate education.

Senator TCHEN—I had not realised that. Otherwise I would probably have put the question to Dr Farrell from the University of Tasmania earlier. I think Dr Farrell and Dr Robinson told us that the third year of the course they are teaching is basically clinical training.

Ms Graham—That is spread across many specialties. That is why no-one gets very much. There is very minimal clinical experience in the specialty areas.

Miss Taylor—And they do not cover all the specialty areas. They are allowed to choose the ones that are of interest to them.

Senator TCHEN—They make their choice.

Miss Taylor—They make their choice of the ones they might be interested in. But there will be some they will have no exposure to.

Senator TCHEN—So basically students in the third year will be required to make a choice on what area to go into.

Ms Wallace—And that clinical choice is often based not on actual knowledge of those areas. It is based often on a public media perception of what might be involved in that area.

Mr Pearson—I think it leads to a real problem in nursing which is that the supervised graduate year which other professions have has not been fully accepted and funded in nursing. The expectation that a nurse can do three years training and hit the floor and be totally competent in every area is unrealistic. In what was called the good old days when hospitals ran on student nurses as the bulk of their work force, quite often we learned our tasks and could function fairly effectively after three years in many areas, but we did not really mature for some time.

Now there is a better theoretical underpinning for our education, but at the end of three years you would need to become proficient in your workplace like social workers, psychologists and doctors do with supervision. That role is not funded. The money came out of the teaching hospitals and that role went to the university and nobody backfilled the mentoring in that graduate year when you need to consolidate your profession. I think that is one of the big lags. I would hate to see the expectation that a nurse after three years can hit the floor and become like that of a nurse with 10 years experience. It is not going to happen. If you want a bit more on this we can get that. In our area in particular it takes time to become totally competent in your field. There are too many nurses doing their first year out over and over again.

Senator TCHEN—Time does not seem to be something that we have. How can we develop a better integration between education and actual training? I suppose, as you suggest, clinical training would be better, but if you specialise in clinical education in the third year you are pushing a student into an early choice. What is the solution to that? The University of Tasmania

suggests a four-year degree. Other people suggest continuing training after coming out of university, Cooperation with hospitals is necessary in both cases.

Ms Wallace—With regard to that, for some years, certainly since the mid-1970s, the one that I am aware of is the Sydney Adventist Hospital and their training college. For many years prior to the introduction of nursing generally into the tertiary sector, they ran a four-year diploma level program for nurses that had six months of theory followed by six months of practice for that entire four years. I think that type of program may produce, at the end, a graduate nurse who has more of the skills that are required by the actual industry that they are going to work in.

Senator TCHEN—So if we concentrate the training—the theory and the practice at the same time—instead of spreading it over a period, do you think we would get a better outcome?

Ms Wallace—Possibly.

Senator TCHEN—Would Miss Pollard, Mr Pearson and the rest of the ladies like to make a comment?

Mr Pearson—It is not all bad news. I think the model in mental health in Tasmania is not a bad one. Certainly the workplaces and the university do work very closely together. The public and private sectors have provided funded positions for postgraduate students, so that they can get their clinical experience and earn an income so that they do not have to get their clinical experience in their long service leave or their annual leave or on their days off. The bones of a model are actually there. It is not all bad news. I do not think we can produce the numbers. The problem with preceptors and the like is endemic right across the system. But I think the model we have here, and the level of cooperation we get, is very good. But Tasmania is different. We have one university; there are not three competing for the clinical placements. It is horrendous in the other cities where the students find it very difficult to get an equal experience. We have made significant strides in Tasmania in the mental health area, and it is not a bad model.

Miss Taylor—The clinical aspect has to start a lot sooner than the third year. The students need to have a fuller appreciation of what nursing is about from the very beginning. They should not just be in a classroom and then suddenly come out into the clinical area in their third year when they are meant to make choices and say, ‘This is the sort of nursing I want to do.’

What has not really been brought out that much is that we have our specialties but within our specialties we have many subspecialties as well. So we can take a graduate nurse but will never train them into an operating room nurse in three months. We can get them to a basic level where they can recover an unconscious patient, but to become a specialised nurse who can do the intricacies of brain surgery, or whatever, takes a lot of time, and many years. If we are going to put that energy into somebody, we want to know they want to be an operating room nurse at the beginning, not that they are there for an interest’s sake.

The only way they are ever going to get that ability to say, ‘This is what I really want to do’ is through working in the area as a paid person, not as a supernumerary. Maybe they could work at an EN level in their third year. Their clinical placement could be the operating room for six months and they would be paid to work. And people would expect them to pull their weight. At

the end of that six months, they could genuinely say, 'This is where I want to go' and then we put our energy into creating the specialist nurse that we need.

CHAIR—In the good old days, when I was doing medicine at St Vincent's Hospital—and most of the people thought I was a nurse anyhow; the advantage of gender occasionally—I had a huge amount of learning that my nursing sisters provided me with. In those days, nurses had about a three-month position, and every three months they would go where they were sent. We would hear the nurses say, 'We're off to do whatever,' or 'Whacko, I'm off to so and so.' They had three months clinical experience. That seemed to me to be a reasonable guess. Why are you saying six months now?

Miss Taylor—Maybe six months is a bit long. I am just thinking that it has changed a great deal and it incorporates so much more under its umbrella now. Operating room nurses work in endoscopy units; we work in day surgery units. It is not just one particular general theatre where you go in and the tasks are very similar. You can go into orthopaedics, which is what I do, but it took me three months just to get the orthopaedics under my belt and I needed the three months to get the general operating room nursing as well. Three months would probably give them a very good idea if it is the career pathway they are looking for. So maybe six months is a little long. It needs to be more extended than the time that they have at the moment.

CHAIR—In answer to Senator Tchen's question, you were all saying, more or less, that there should be an agreed amount of follow-up study. What would your comment be if I said something inflammatory like this: I think operating room sisters need more experience, or a longer term to get their hands on the job, than, for instance, aged care nurses? This is inflammatory. I have just managed to skip all those mental health people who are coming straight over the table at me! They have much more chance to 'kill' people very quickly. Those sitting at this end of the table can 'kill' people in half an hour, while you are going to take a bit longer.

Ms Wallace—You are going to take a bit longer to 'kill' them, but you might do a lot of other damage to them. You could eventually 'kill' them.

CHAIR—It is just that there is an immediacy about some parts of nursing care. It is the same with emergency care and so on. It is not really good to have someone in emergency, while the patient is bleeding, saying, 'How do you stop the bleeding?' I think there is an element there that we all recognise—there is an immediacy about some parts of nursing care that distinguish them from others. For instance, in the mental health area, you need to know when somebody has just moved into a psychotic episode, or something of that sort, that requires very different treatment from what you might be doing in the management post that acute phase. For aged care, I quite agree, Ms Wallace, that you can do a lot of damage. Would you say that you needed the same amount of training for each of you?

Ms Wallace—I think you need the basic training, and then possibly you do need close to the same amount to become very skilled in your chosen area.

CHAIR—Yes, I appreciate that.

Senator TCHEN—Without knowing how the graduate nursing courses are being structured at the moment, can I summarise what you are suggesting to me: you are talking about a model, even the mental health nursing model, which is very similar to types of medical training models now. I understand that second-year medical students are now in the clinics and are actually learning how to deal with people. I assume that a nursing student is not doing that. If they get exposed to the hospital environment and the clinic environment earlier, and the course is structured in such a way that they get hands-on training all the time, that would be better, in terms of both their quality of training and their ability to specialise.

Ms Wallace—Yes.

CHAIR—That is a very good point, Senator Tchen. There may be questions that we will want to put to some of our previous witnesses. I have said one thing that you all coped with, when I said you can 'kill' patients at this end of the table much quicker than you can at that end of the table. I liked reading in this document that you only chose mental health nurses because they were able to win in a fight. I have read some good things. It reads:

> Mental health nurses were historically chosen more for their ability to handle themselves in a fight than for their interpersonal skills. This perception still persists.

I presume this was a perception and not an actual criterion in the past?

Mr Pearson—For those of us who have been in the work force for a fair amount of time, and I think most of us have, there was a time when patients in psychiatric hospitals were split along sex lines, for a start. If you looked at the male nurses who were there, a lot of them in the acute areas seemed to be large.

CHAIR—They reminded you more of jail warders?

Mr Pearson—Very much so, unfortunately.

CHAIR—I have spent some time in this area of medical specialty.

Senator TCHEN—I can appreciate Mr Pearson being able to win fights; I cannot quite see Miss Pollard being able to win fights.

CHAIR—She is only fighting women!

Miss Pollard—I do lead the aggression response team at the Royal Hobart Hospital.

CHAIR—It is a very interesting thing—retaining nurses. You are saying that one of the things you have to do is to change the perception that you need to be able to 'martially art' them to the floor?

Mr Pearson—It is to change the perception that other people have of the work that we do and of the sort of people that we are. It is not only the public but also the other professions. One of the problems in nursing generally is the lack of respect that other professions have for nurses. I work in the private sector. It is interesting that, at the moment in Tasmania, my organisation is

assisting in funding a research project to look at violence towards nurses in the workplace. The violence does not involve being thumped but being abused verbally with a lack of respect being shown to you as a nurse within your workplace by your nursing colleagues and by your other professional colleagues as well as your patients.

CHAIR—I think most of us would at least understand violence by patients to nurses. I do not mean that they should accept it, but there are times when patients are terribly stressed or shocked. They are raced into casualty. They are upset or in accidents, in a psychotic episode or what have you.

We have been introduced to the concept of horizontal violence. All of us got it wrong. I must say that I was off the mark most, I suppose. Horizontal violence certainly did not seem to me as abuse by colleagues, but I do have a flexible mind. That is what you have just described?

Mr Pearson—Absolutely.

CHAIR—Does horizontal violence refer to the medical people getting stuck into the nurses?

Ms Wallace—All professions.

Mr Pearson—All professions. There are papers about this; they say that nurses eat their young.

CHAIR—I have heard that expression. I thought horizontal violence mainly referred to nurses on nurses rather than other professions on nurses.

Ms Graham—It originally started with that, but the definition has become broader and other disciplines are also accepting it as a definition of violence between the medicos to the nurses, to the radiologists, cardiologists, and social workers. It was originally nurses to nurses.

CHAIR—So if you are looking at the nursing profession and trying to address this question of violence, can you therefore do it without recourse to dealing with violence in an institution among all the professionals?

Mr Pearson—That is what the study is meant to get a handle on.

CHAIR—How do you go teaching people about the difference between mad and bad or do you ring Russell Crowe and thank him very much? Have you seen *A Beautiful Mind*?

Ms Graham—I have not seen it but the people who have seen it and who are mental health trained do not think it is very good.

CHAIR—Because?

Ms Graham—It portrays the wrong image of someone with schizophrenia.

CHAIR—What sort of image?

Ms Graham—I have not seen it myself. I have forgotten the words that they used to me. It was just that it undervalued it. I am scratching for what was written.

CHAIR—If you have not seen it that is okay. I have heard other people tell me that they thought it was a fantastic treatise on schizophrenia and that it really made it a much more real situation. Instead of the world being terrified of anyone with schizophrenia—or as in the past with the madder Hollywood portrayals, all with split personalities—this is a much better real world portrayal of it.

Ms Graham—I have not seen it myself. This was a psychiatrist friend of mine who saw it. He was quite horror struck by it. He thought it was not good at all, but then he is a psychiatrist.

CHAIR—I think it is an interesting thing because a lot of people in the community see this as a big help towards outing a psychiatric illness and making people know that there is a difference between mad and bad. The other problem is that, in the past, as I understand it, a lot of people see all psychiatric patients as basically stupid. It is a shock to them to discover that you can speak to them and they will say ‘Hello’ back. I think there are a lot of educational perceptions there. Does that also pertain to nurses?

Mrs Polanowski—It does in trying to attract a person into the field. There is as much misperception in undergraduate nurses as there is in the general population.

CHAIR—So how long do you need to have an undergraduate nurse experiencing care of psychiatric patients or mental health patients for them to feel differently about it?

Ms Graham—We suggested in our submission that psychological theory and personality development—those types of subjects—should be introduced very early on in undergraduate curriculum. It would help to get people just thinking about how we develop mentally and psychologically. Then a decent—

Mrs Polanowski—Exposure at an undergraduate level.

Ms Graham—Yes, at least a three-month exposure. I think they have six weeks—again, if they choose that.

Ms Graham—Yes, at least a three-month exposure. I think they have six weeks—again, if they choose that. I was involved in the employment of many of our postgraduate students. They would say that, during their six weeks in the psychiatric mental health field, they suddenly found that this was their thing. They loved it and had not even thought about it before that final year of nursing when they thought, ‘Oh, wow’. So they asked for a placement during their postgraduate year and have now entered training—but students need the exposure.

CHAIR—I have a question directed particularly at the operating room nurses, but it is for all of you. My question relates to lecturers retaining their clinical competence: can each of you briefly tell us about that? Five years out, they do not know which end of a scalpel is up. I am being flippant here because I know what you mean about new equipment and so on. The procedures are extremely different even from five years ago, I should have thought. Tell us a bit about what you mean by maintaining clinical competence.

Miss Taylor—What we would like to see is that the people who actually lecture in our specialty have some credibility in that specialty. We have had an incident where we have had to, as an organisation, address and write a letter of complaint to the university because the person who was lecturing in a field was basically saying that it was not a worthwhile field. The person had no credibility in that field and had never actually worked in that field. We feel that the people who are going to lecture should have a good understanding of the field. In order to maintain their clinical credibility, they need to be seen working in that area—whether it is a day, week, month or whatever—with us to have the credibility and understanding. And then they can go to these brand-new people who are basically forming their nursing career and they can give them a truthful insight into it that is not biased and that actually says, 'This is a worthwhile part of nursing as well as aged care' or anything like that. It should stand there at the same level as all the others—not that it is not task orientated so don't worry about it. That is where we would like to see them clinically competent and credible.

CHAIR—I will add, for your consideration in answering this question, that we have just heard from the Nursing Board. The person brought to our attention the fact that clinically competent (operating room) nurses, for example, are doing the teaching of people from university, when some of the older people in the operating room have 15 years of real world experience and perhaps know far more and would be able to teach but they do not have the university qualification. The board accepts that, but the profession is not so inclined to accept that. I think the board says, 'We don't mind where you get your competence, but from here on in you get your competence through university.' I am particularly interested in your comment about that. You want the people teaching operating room nursing to have a clinical and a real world experience. Does that mean that, if somebody were teaching, they would have to either be in the operating room or come in and out of it?

Miss Taylor—They would need to have a regular contact with it. We have educators in operating rooms and it would be very good for them to go into the universities and have a shared experience and interchange. They could go and lecture in that component, and so the clinical component is taught by people who have that experience. And the university lecturers who would deal with everything around it could come and see what it is all about. So the credibility is on both campuses, the clinical and the educational.

CHAIR—Is that happening at all?

Miss Taylor—Not in our area.

Ms Graham—It happens in mental health. We are very fortunate to have two that I know of: one undergraduate lecturer and one postgraduate lecturer who also have clinical loads.

Miss Pollard—One is in a co-joint position.

Ms Graham—Yes, one is in a co-joint position and one chooses to work part time in both.

Ms Wallace—In aged care there are currently two directors of nursing from a facility in Launceston and a facility here in Hobart. They are guest speakers to undergraduates, but it is only little one-off things. I think what the lady at the end of the table was saying is that they

need to have some enthusiasm for the area that they are working in and to impart some of that. You really only have that if you, in some way, work regularly in that area.

CHAIR—That is a very useful series of answers and I like the idea of enthusiasm.

Senator TCHEN—I have a general question about career path. I believe all of you have touched on this and some of you talk about it in terms of attracting people or keeping people but basically it is about a career path. How can we develop a career path in nursing which will be attractive to young people—or maybe not so young people—coming into the profession?

Miss Taylor—In other careers you have a greater ability to make more money as you gain experience; we are locked into a level. For example, I have 20 years experience and I have a master’s degree, but because I choose to work in the clinical area I get paid the same as someone who has eight years experience.

Mrs Bingham—Or one year.

Miss Taylor—Or one year. There is no encouragement to move on and make a career pathway if you wish to stay in a clinical setting. You have to move out into administration, education or something like that, so that career pathway is lost to the clinician.

Mrs Bingham—I might also just add that a level 1 beginning practitioner who does shiftwork may well earn more than a more senior nurse who, for whatever reason, works Monday to Friday. That is always a difficulty in providing a career path and attracting nursing staff.

CHAIR—So one of the challenges that follows from that is that if you were working in the operating room on a casual basis and doing shiftwork, you would be earning more than if you were faithfully there for 20 years.

Miss Taylor—Absolutely.

Mrs Bingham—Absolutely.

Senator TCHEN—So that is really no recognition of skill.

Miss Taylor—No recognition of skills and no recognition of qualifications either. We are recognising qualifications now with our enterprise bargaining agreement, but the qualifications required for certain levels of nursing are not recognised for the responsibility those levels often have.

Senator TCHEN—Is that because the job requires only one level of skill?

Miss Taylor—No, it does not require one level of skill. It requires a whole range of skills from beginner to an expert practitioner, but the pay scale—

CHAIR—One should not get into grading these things, but I do think that if I were having my brain operated on I would like to have some very skilled theatre sisters.

Miss Taylor—Exactly, but she would be paid the same as the person who had just come in as a grad nurse. That is not really a way to create a pathway to attract people.

Ms Graham—You do not get to choose your nurse.

Senator TCHEN—What about the mental health and community health area?

Ms Graham—We certainly agree with Helen. It is the clinical line that is lost. If you wish to go on and earn more money you have to go into admin, management or another field. We lose excellent clinicians to admin.

CHAIR—Are there any other comments?

Mr Pearson—It is a problem in nursing generally because of that. Our career structure has been emasculated over the years. Levels have been taken out and it is called flattening.

CHAIR—A very advertently used word there, Mr Pearson?

Mr Pearson—No, there is not a unisex word for it. I would have used it if I could have thought of it. So the career structure has been flattened, which means—

CHAIR—Was there one before?

Miss Pollard—Briefly.

Mr Pearson—Briefly.

CHAIR—When?

Ms Graham—In 1990 it came in.

CHAIR—Tell us a bit more about that.

Ms Graham—I was not part of Tasmania when that was happening but I came back. There was a good career path into education, research, admin and clinical.

CHAIR—Was that Tasmanian?

Ms Graham—That was a Tasmanian version.

Mr Pearson—It was a Tasmanian version. It probably started in the career structure in South Australia—I came from South Australia.

CHAIR—Those of us who do, Mr Pearson, are blessed.

Mrs Bingham—I was practising in the public health sector when a career structure first came in. At that time we had—I am just talking about the operating suite—charge nurses who were in charge of various theatres. They were the sisters and everybody else was the same level. The only difference in pay was according to your yearly increments. What career structure did was to recognise that there were clinicians between the beginning practitioner and the charge nurse who were in fact practising at a much higher level than each other. The idea of career structure was to recognise that by introducing a level 2. So it was somewhere between a beginning practitioner and a charge sister.

They then also recognised that as well as being in charge of an area there were other areas that had as much responsibility, such as in staff development, in education or in managing the unit, so they had a number of people at that level who could focus on specialty areas. What has happened subsequently is that it is really very hard to get a level 2 position because there are fixed numbers within an organisation and once that quota is filled then that is it until the person leaves, retires or dies. So that by the very nature prevents a lot of level 1s from actually getting that next step. They have to wait for someone to vacate before they can get there. That was never the idea of career structure. So we are not rewarding people for clinical skills until someone vacates a position. With the level 3s, a lot of those positions disappeared about four or five years ago because they are expensive. Therefore, to get a level 3 position as a clinical nurse consultant again you have to wait for someone to retire, which will be in about 10 years time, before you can get one. Then there were level 4s who looked after a broader area, say a division of peri-operative services or day surgery. That all got flattened out as well so you lost your ability to step up. The career structure as it started out really did give nurses an idea of ‘yes, here we go’, but in the last 10 years, as has been said, it has been flattened so far that there is very little opportunity to move.

Ms Pollard—Certainly in positions like the clinical nurse managers when they are vacant they are just not being filled because the other levels—the level 2s and the level 1s—have watched what a horrendous position it is and monetary remuneration is much less so even that senior clinical level 3 right across the nursing profession and levels is—

Mr Pearson—They are hard to fill.

Miss Pollard—They are very hard to fill.

Senator TCHEN—Can I assume that in the aged care area the situation is even worse, Ms Wallace?

Ms Wallace—In aged care there has never ever really been a career pathway to follow and most of that is related to the fact that there is no funding.

Senator TCHEN—Because in aged care you are getting the situation where the registered nurse quite often happens to be the only nurse?

Ms Wallace—Probably. There is no pathway to go. You are either the level 1 on the floor or you are the person running the place and there is very little in between.

CHAIR—Is there a career possibility for an aged care nurse after five or 10 years to then move into another specialised postgraduate area and get a career path that way?

Ms Wallace—Yes, but then they leave aged care.

CHAIR—Quite so. How high is the priority for career path?

Ms Wallace—It is the only way of attracting new people to come. Really, in all the fields of nursing the average age is old. I am the youngest aged care director of nursing in this state by some years and I am over 40.

CHAIR—Shock, horror! That is dreadful.

Senator TCHEN—That is quite young actually.

Ms Wallace—But there is nobody young at all. There are no nurses in aged care who would be under 25—or very few.

CHAIR—Senator Tchen, you were asking other questions. I am sorry I interrupted you.

Senator TCHEN—That is quite all right. I was just thinking that this is a question that everyone has referred to. I would now like to move to IT support and linkages. I think the issue probably came from you but it probably applies to other people as well, particularly in the Tasmania context.

Ms Graham—I think it probably does apply across the board.

Senator TCHEN—Can you expand on the benefit of such a program?

Ms Graham—At the moment this area does not know what that area is doing. We have a group of clients in mental health that belong to Tasmania, if you like, but they often go from one clinic to another or move around within the state. It would be so much easier if we had a linked system so that each nurse—we will say nurse—could just click into a computer and see if this person is known somewhere else. It would save an awful lot of time.

Senator TCHEN—You are actually talking about a database which allows you to refer to people and refer the issues, rather than just having the hardware.

Ms Graham—Yes, but it is also having IT available, having computers in the workplace which are almost non-existent in the mental health field.

CHAIR—When do you get time allocated to learn about computers?

Ms Graham—We don't any more.

CHAIR—None?

Ms Graham—No, not any more.

CHAIR—How many of you have been able to apply for a $3,000 grant with which to buy your computer, as the medical profession has been?

Ms Graham—I haven't.

CHAIR—I am just being cynical on behalf of the nursing profession at this time.

Ms Graham—Thank you.

CHAIR—I am very interested in that answer, though, because if the medical profession is actually moving online and looking at, as it is, all sorts of databases and walling around a general practice, or data between a general practice and the related hospital and so on, it would seem to me to be a very important question that I think all of you can perhaps take up with your academic colleagues. Where is the position of nursing in that, seeing that you do a huge amount of hands-on care that needs to be in that database? For example, Mrs Jones has just come home, post-operative. She is theoretically awake from the anaesthetic but most of us know it is going to take a few days, if not a week, to wash out of her system. If she is lucky, she has somebody at home to help her, otherwise the good community health nurse is around. Where is there the capacity for the community health nurse to input that data into the general practice database about that patient? It would seem to me a very interesting question, so I think perhaps we had better make a note about that and see if we can get any further information about that.

Ms Wallace—On that point, recently the Division of General Practice in Hobart ran a trial at one facility with computerised medication ordering, computerised drug charts. The Division of General Practice had a meeting with a lot of aged care facilities and basically wanted all the aged care facilities to have the most common software that the doctors had to enable them to do that. They were horrified when it was put to them, 'Well, who is going to help us buy the hardware and the software?' They all just said, 'We get it provided.' They were horrified to realise and sort of shut up fairly quickly when they realised that it was not the path to go down.

CHAIR—To the rich more is given.

Ms Wallace—Something like that, yes.

Senator TCHEN—Supposing funding can be found to bring nurses 100 per cent online, what would be the basic unit at which this contact point could be based? Say each aged care facility with residential care will be online, but what about the other areas?

CHAIR—Where, if you were the community mental health nurse, would you put your computer?

Senator TCHEN—Ideally, everyone would carry their own computer on their wrist.

Ms Graham—I see all nurses who work in the community, whether they are mental health or community generalist nurses, should have laptops. I have seen it work in one of the private

nursing services in Hobart and it works very well. It is downloaded into a—I do not know the term—large computer when it is back at the work site. That way they still have linkages. If they are sitting in their car and they have just seen a client, they can go online and find out maybe who the GP is or when the medication was last changed—immediate things, without having to go back to the office and make numerous phone calls, are all there.

CHAIR—It does raise extremely significant questions. I think Senator Tchen's question is the first very tough one; where will the mainframe or the main access be put in? Where do you log your laptop in? Laptops are fine, but they belong to some hard disk somewhere, so where is that going to be?

Ms Graham—I cannot answer that. I do not know enough about computers to know what needs to be.

CHAIR—It is easy enough. Do you have a community health centre that you work from?

Ms Graham—Yes, most people have a site.

CHAIR—It might be based in your workplace of that sort. But the next thing is: who has got access to it and how can you actually look up anything and be accepted as having access but not infringe privacy regulations about a doctor-patient relationship down the road, for example? These are major questions that need to be seriously examined and I am really appreciative of that question, Senator, because it is something to this point we have not been pushing too hard. It is a very important question. Senator Tchen, did you have something to follow on that?

Senator TCHEN—No. That is about it. I have run out of ideas but I am very appreciative of your support of me.

CHAIR—I want to push the IT a little further too in terms of remote area education. Do you believe you can have virtual reality operating theatres?

Miss Taylor—It is not the same. It would be part of the teaching tool but it will never replace the actual reality.

CHAIR—Because?

Miss Taylor—I do not think in virtual reality you learn the intuition that tells you when something is not quite right, which you get by feeling a patient's hand when they are under anaesthesia. You can tell just by touching them that something is not right; their skin is warm or clammy—just the little things you learn to pick up by actually having direct patient contact. I do not think in a virtual reality situation you can ever get that.

CHAIR—Does virtual reality give you the banter of a—

Miss Taylor—That is important too—and the music choice is very good as well!

CHAIR—The point scoring or the down-putting. There is still, I believe, some of that.

Miss Taylor—Yes, there is.

CHAIR—So you are suggesting that virtual reality might at least allow you to run through equipment, for example, or the shape of a bed and lights, but it would not necessarily give you what happens when the world really starts.

Miss Taylor—It can give you what the steps should be and it can throw in different things that may go wrong—and how you would react to it— but the actual reality is that when something goes wrong other things are also going wrong and so your ideal response is not going to happen because you are dealing with things that you could not possibly have planned for that are also happening around you.

CHAIR—Are *All Saints* or *ER* a help to your recruiting?

Miss Taylor—Not really, no. It is very glamorous but it is not like that.

CHAIR—I am interested in terms of *A Beautiful Mind*—that it may or may not help with recruiting. But some of the movies on hospitals and doctors and nurses are not all negative.

Miss Taylor—No, and they take scenarios that are very real—but it is like one dramatic thing after another. It does not take out the fact that all jobs become very mundane for 90 per cent of the time but they are all important.

CHAIR—Would virtual reality help with mental health situations?

Ms Graham—No, because again it would be the nuances.

Miss Pollard—The pace that you would not be able to see— the stance of the person, the eye, that you would not be able to see.

CHAIR—Do you mean speed or stepping?

Miss Pollard—Both. You would not be able to see the warning signs. You would not be able to see that initial anxiety and fear and the non-verbal cues that you need to see with the naked eye. You need to have your reality nurses' gut there.

CHAIR—And aged care?

Ms Wallace—Maybe for purely technical techniques to learn, but I do not think virtual reality can replace the person with dementia and how you deal with them. They are all so very different. You could not possibly plan or anticipate, and most people, particularly in high-level residential care, have some marked degree of dementia.

CHAIR—We have got to finish now but those comments went very much to a dimension of this inquiry that is critical: what is the nature of nursing? It is something more than what virtual reality can give us.

Back to training for precepts: how does a person become a preceptor?

Mrs Bingham—There are a couple of ways that that can happen. The Nursing Board of Tasmania runs a preceptor program and the hospitals themselves may offer preceptor programs. So someone who is in the work force who would like to pursue that as an additional skill, for professional development, has got the opportunity to do that often in-house and, if not, through the Nursing Board of Tasmania. They then basically receive a certificate and each year they have to re-present some information to maintain that qualification as a preceptor. They are then obviously allocated to preceptees on a regular basis within the workplace so that they can maintain those skills. The areas that are specifically looked for are their ability to assess someone's competence and their ability to clinically work with someone and teach them on the job. They are the two main components of preceptor training.

CHAIR—That is extremely helpful. Thank you.

Ms Graham—We are about to formalise the preceptor training in Tasmania. At the moment it is done by more than one facility or group. It is very close to being one acceptable course.

CHAIR—Is it going to be a course at university?

Ms Graham—No, but it will governed in a way by that, I think.

CHAIR—So we will have university teaching being done by non-university-qualified people?

Ms Graham—Some.

CHAIR—It is an interesting point. So how does a person become a preceptor? Are they dobbed in—'You look as though you could do the job'—or do people put up their hands?

Ms Graham—A bit of both.

Mrs Bingham—It is different. Within a level 2 position description there is a requirement for them to act as a preceptor. Therefore, to fulfil that requirement, if you are doing appropriate performance review and development annually, they should have to undertake preceptor training to be able to fulfil their role as a level 2. For other levels of nurses there is an interest in teaching and education. They can volunteer to enrol in a preceptor program or they can be heavily encouraged by their peers and colleagues. Some people have a knack and that becomes obvious. You do like to use the people that you can see have that affinity with new students, who can not just teach them the practice of that particular specialty but can teach them the culture, behaviour and attitude that is required to perform at your best and to provide the highest standard of patient care. So it is more than just the clinical that you need to teach them; it is the whole cultural thing within a specialty.

CHAIR—Just as we finish, would each of you, if you do not mind, tell us why you stay nurses. In a sentence, why do you stay in the nursing field? What do you reckon is the highest priority to get the young folk to come in and find out what your passion is?

Ms Wallace—I think I stay a nurse because deep down I actually enjoy it. I enjoy the people contact. The thing to encourage people to choose it as a career is to demonstrate, as I have said previously, some enthusiasm and sense of achievement.

Mr Pearson—After 26 years, why do I stay in it? I actually like it too and I like the people. I like the patients, generally speaking. It is an undervalued area but it is also one that has got some really interesting experiences in it. There are a lot of interesting people who work in it too. There is the other sort of work in it as well, like any other work force, but it is the people, the patients and the other people I work with—certainly not for the money.

Miss Pollard—I really believe in my specialty. That is why I have stayed in mental health and not gone back to general nursing. I think national wage parity would help with recruitment.

Ms Graham—I am in it because I love it. I am very enthusiastic about nursing and certainly the wage parity with other states would help as well as the pay parity in the organisation we work in for the same job.

Mrs Polanowski—Touche. I really enjoy the job that I do; I find it rewarding. But to attract people into nursing in general and into mental health I think career structure and pay parity are probably the two biggest issues. When people are faced with choosing a career path through university, pay parity, structure in career and what they are going to get out of it at the end of their three-year or four-year degree are what they look at. If we had some parity there, it would be a better choice for people.

Mrs Bingham—I love my job. In a management role, the thing that gives me the biggest buzz is being able to empower clinical nurses to be able to do their job as clinicians to the best of their ability. In terms of attracting new graduates specifically to the area of perioperative nursing, we have to dispel the myths and misconceptions about what operating room nursing is about. That is the biggest challenge that we face.

Miss Taylor—I love my job, too. I have always wanted to be an operating room nurse. The biggest bonus to me with respect to the recruiting of nurses would be the clinical career pathway, salary parity and more respect from our colleagues for the job that we do.

CHAIR—Thank you all very much for that because I think it is good for the Senate team on this side of the table to recall our terms of reference somewhat differently from how they are written. Also, this is really what we are looking at. We have heard from many witnesses what a tough game the nursing profession is at the moment. It is really interesting to know that, tough and all, that is where you are staying. Thank you all very much.

[3.31 p.m.]

CROWDER, Mrs Kerrie Davidia, Departmental Liaison Officer, Minister's Office, Department of Health and Human Services

de SILVA, Ms Rae, Co-Director of Surgery, Royal Hobart Hospital, Department of Health and Human Services

CHAIR—I welcome representatives of the Department of Health and Human Services. I want to thank you for cooperating. Instead of being here this morning, you are appearing last this afternoon, so I thank you. While I am thanking people, I would also particularly like to thank the Hobart Town Hall—the people who have provided hospitality for us today. We appreciate that.

Ms de Silva—I need to apologise on behalf of the representative of the Family, Child and Youth Health Service. Because of the change of time, she was not able to come this afternoon.

CHAIR—Is that Mrs Shaw?

Ms de Silva—No, that is Christine Long, whose name appears in the original program—submission 817.

CHAIR—Could I ask for a little more detail about what your role in the Department of Health and Human Services is.

Mrs Crowder—My role is within the minister's office as departmental liaison officer.

Ms de Silva—I am based at the Royal Hobart Hospital. I am the nurse co-director for surgery.

CHAIR—Thank you. We prefer all evidence to be heard in public but, if you wish to give any of your evidence or answers to specific questions in camera, you may ask to do so and we will give consideration to your request. The committee has before it your submission No. 923. Do you wish to make any alterations to that submission?

Ms de Silva—No, we do not.

CHAIR—I am afraid we have to end this meeting at 4.30, so if you would like to make an opening statement and then field questions that would be great.

Ms de Silva—I do not actually have an opening statement; it is more about the issues that we would like addressed.

CHAIR—That is fine.

Ms de Silva—There are about half a dozen issues here. Tasmania being a regional area, certainly we have got recruitment and retention issues, particularly in the rural areas. If there are difficulties—and we all know there are—in recruitment and retention for urban areas, these issues are amplified in rural areas here in Tasmania. An example I can give is that of Queenstown Hospital. Another issue of importance for us is the role of the nurse practitioner. We have not implemented that model yet in Tasmania, but we are certainly learning from elsewhere. We are still looking to develop an appropriate model for Tasmania. That is still under discussion but I am just putting that on the table as well.

The third issue is the importance of differentiating between the categories of nursing. Some people call it the two tiers, as in registered nurse and enrolled nurse, and the importance of actually defining the scope of practice. We have certainly tried to define that here through our work force planning report, which has recently been launched by the minister.

CHAIR—Do you have a spare copy of that report? If you could provide a copy to the committee, that would be wonderful. Thank you.

Ms de Silva—We can, yes. So that is differentiating between the two levels of nursing. This would give an opportunity hopefully to rationalise and review what the nursing duties are in order to bring it in line with what university entrants expect of the role of a registered nurse. We have got anecdotal evidence from talking to new graduates as to what they feel the role of nursing should be, what it is now and what they see as important aspects of it.

The other issue for us, too, is that the main campus for the undergraduate nursing course is in Launceston. Again, for us anecdotal evidence has suggested that this could be a deterrent for what we call the southern residents who are potential nursing students from choosing nursing as a preferred course in that they will have to go elsewhere, to leave home to go to Launceston.

Lastly, it is about unregulated health care workers and what their role is, if any, in health services. We have included with that—it may not be an appropriate inclusion—the employment of students at undergraduate level. I know that in states like South Australia and Queensland that has happened or is about to happen, and here, too, we are looking at how to implement that, the issues involved, who would benefit from it and to what end we would be employing undergraduate students.

CHAIR—Do you have anything to add at this time?

Mrs Crowder—No.

CHAIR—Before we move to those points, and before I ask Senator Tchen to take some questions, on the nursing shortage: are we agreed there is one?

Ms de Silva—Yes, there are shortages particularly in specialist areas in Tasmania such as operating theatre, neurosurgical nursing, emergency care and aged care. That statement could be made across the board, but specialist areas are where we are acutely short.

CHAIR—So the shortage is across the board, but it is particularly the case—

Ms de Silva—In some specialist areas; that is right.

CHAIR—To what extent do you worry about nursing shortage in aged care? It is not your business, is it?

Mrs Crowder—No, although the state does provide aged care services. We do have some beds, so from that perspective we are employers of aged care, but it is a very small amount, I must admit.

CHAIR—Do you think the wage disparity between nurses in Tasmania vis-a-vis the mainland is a contributing factor to that shortage?

Ms de Silva—The wage disparity is, in some ways, quite subjective because dollar for dollar there may be a disparity. For example, someone in my position in another state would certainly be earning a bit more than I do now, but my position here is a permanent position whereas a similar position in a similar hospital, say, in Victoria, would be a contract position. I would say that is part of the explanation for the disparity. With our last EBA—enterprise bargaining agreement—it has brought it pretty close to other states.

CHAIR—About $43,000, is it, to start off with for a RN?

Ms de Silva—For a first year RN, no, it is not $43,000. It is closer—

CHAIR—If you could provide us with the wage scales, that would be really useful.

Ms de Silva—Yes, we can certainly do that.

CHAIR—Would you mind doing that for ENs, too?

Ms de Silva—Yes.

CHAIR—Thank you. And any other wage information that might be of assistance would be helpful. We have certainly had it before. I have had it in the area of teaching—that people would be much better off going to the mainland because they get $4,000 or $5,000 more, which is probably what I think is the discrepancy here.

Mrs Crowder—It depends, too, on which stage of the EBA you are at. Once you get a new EBA, if you have just negotiated yours—for example, Queensland's is four years old—you are going to become closer to them. So they are different. Wage parities this year and last year would be totally different depending on where you are in the EBA cycle.

CHAIR—I appreciate that. That is very helpful. People also point out that of course the cost of living may be more expensive and if you do not take that into account you could be a bit wrong.

Ms de Silva—That is why I say it is subjective; it depends on who you ask. Others see it as, 'Okay, I might earn $5,000 more elsewhere, but my house is going to cost more as well if I lived elsewhere.'

CHAIR—We have been hearing interesting evidence about why there is a problem with retention. On the evidence we have been given, recruitment is not a problem. That is to say, there are more nurses and more people applying to do nursing than can get places. A lot of EN nurses who have an automatic entree into RN courses simply cannot get there because there is not a place. So it is all very well to say to the ENs that they can move up. They know they can theoretically, but there is no place for them anywhere. Some might get one, but a large number who want to cannot get there. So it seems that getting them in is not the main problem; it is keeping them. Can you comment on what you understand is the principal reason why people are leaving nursing, and at what time in the nursing lifetime does that happen, to your understanding?

Ms de Silva—From what I see in Tasmania we do have people leaving. The younger ones leave because they travel; nursing has always been that sort of profession from way back. I trained 30 years ago and even then, of course, one of the first things you did as soon as you finished your 12 months was to head off elsewhere. So I do not think that has changed. Even the university graduates are off to work elsewhere for experience et cetera. The other reason for leaving, again in Tasmania, is for partners' business or work opportunities, so they have to go elsewhere. That again is not any different. But there are people who leave because the profession is not what they thought it would be. Sometimes they come to that realisation quite early after they have graduated. Others prefer to do work that is related to health care, not necessarily in clinical nursing.

CHAIR—We have been told that the largest number of nurses leave in the first year, the first two or three or four years after they graduate. In particular, we have been given evidence that nurses often arriving to be a full-time nurse, first year out of university, RN 1, are 'gobsmacked' when they hit the wards. I wondered if you could comment about that, especially as we heard today that the last 12 months of the undergraduate nursing course in Tasmania is a full clinical year and, if that were the case, it seems a little contradictory that they would then be 'gobsmacked' when getting on to the wards.

Ms de Silva—Certainly, in the past few years we have offered the fourth year. They have graduated, but the first year out of graduation is what we call their 'transition year'. So for the 12 months they are employed, paid as a second year registered nurse and given full clinical support through preceptorship. I heard someone talk about preceptorship before. Speaking about acute care, the hospitals, we certainly have an attrition rate because nurses have decided to go to Melbourne to take up some other opportunity, but most of them have stayed their 12 months. Indeed, some of them have taken up, in hospitals, their second year, where we provide a greater degree of rotation to give them exposure to other specialties which they did not have at universities.

CHAIR—Are you talking about undergraduates here?

Ms de Silva—Yes, I am talking about the graduates here.

CHAIR—Undergraduates?

Ms de Silva—The undergraduates and the graduates who have finished in their first year.

CHAIR—You started off , as I understood it, talking about an equivalent to the fourth year—their first year in clinical practice, with a preceptor, which is really like a transition year.

Ms de Silva—Yes, that is right. It is like an internship year.

CHAIR—And then there is another year after that?

Ms de Silva—We started introducing that as the second year of rotation for those who wanted to and the reason for that was to give them greater exposure to other clinical areas where they did not get the opportunity in their first transition year.

CHAIR—Is that a three-month rotation?

Ms de Silva—Yes, that is right. They pick areas like the operating theatre, which they normally would not pick in their transition year, and paediatrics, which many people find daunting until they have a bit more experience with sick people.

CHAIR—You are actually incorporating what was the practice many years ago.

Ms de Silva—In some ways, yes. The more things change the more they remain the same.

CHAIR—How have you managed this vis-a-vis universities? That is to say, is there a continuing education dimension to this? Is there a university contribution of theoretical material to it?

Ms de Silva—Not at this stage. The transition year is more the consolidation, so it is the local management, so to speak. For example, if it is a hospital that we are talking about, it is managed by the hospital. They have educators who are trained to work with adult learners. That is how we do that, by offering support via our own employees. So the university had done their three years in the support.

CHAIR—If they get rotated into paediatrics, are they able to do that as part of a certificate course, or whatever I might like to call it? I have never met a professional area that has so many subplots and words. If you were doing a rotation for three months into paediatrics, could you, at the same time, get some kind of academic backup?

Ms de Silva—No. The reason is that there is a graduate certificate offered in paediatrics.

CHAIR—And you cannot apply for that in your second year.

Ms de Silva—Usually the prerequisite is at least two years of postgraduate experience. We certainly have a full intake for paediatrics.

CHAIR—Those certificate courses are done not at university.

Ms de Silva—It is a partnership between the hospital and the university and the title is graduate certificate, so that implies university input.

CHAIR—Can you do certificate courses in the hospital only?

Ms de Silva—Not in Tasmania.

CHAIR—Can you do any TAFE certificates, postgraduate?

Ms de Silva—Not health related; that would be of the standard for—

CHAIR—That is fine. I am now clear in my mind.

Senator TCHEN—I have a quick question on the disparity between different streams of nursing. I understand that the disparity between the Tasmanian pay scale and the mainland pay scale is not a great problem. In fact, my Tasmanian colleagues tell me that Tasmanians get paid less because they get to live in Tasmania.

Ms de Silva—Yes. That is right.

Senator TCHEN—In Tasmania there is a disparity between—I know aged care nursing is not a state responsibility—aged care nursing and other types of nursing? Do you see that as a problem?

Ms de Silva—We would see that as problem in that, if we were to advertise positions—I cannot say that I have seen it yet—perhaps an aged care nurse might see it as an opportunity to move into acute care and earn more dollars, but so far we have not actually seen that sort of thing happening.

Mrs Crowder—The pay scales have been historical. Over time, the acute public sector were paid more than the acute private sector, who were paid more than aged care. What we are seeing now is that the private sector and the public sector are very similar in their wages. They have had to be to attract staff. And the aged care sector has been unable to catch up with that because they have not got the money to pay their nurses parity with the acute sector. So it is an historical thing.

Senator TCHEN—Ms de Silva, you just explained that the Tasmanian nurses education system now consists of a three-year degree, the third year of which is actually in-clinic training—

Ms de Silva—Yes. That is the university component.

Senator TCHEN—where student nurses will work under the supervision of preceptors. After they graduate, they do another year in hospital in-clinic training. That is in the public system.

Ms de Silva—It is in the public system. The private system also employs them, yes.

Senator TCHEN—And they are paid at the second-year level?

Ms de Silva—Yes, that is historical as well.

Senator TCHEN—In recognition of their graduate status. After that, can they move on or do they have to work another year before they can go?

Ms de Silva—Only if they wish to. That is just an optional thing for those who wish to remain a second year.

Senator TCHEN—That would bring their skill to a higher level. You mention in your submission that Tasmania has developed a coordinated market approach to ensure nursing remains competitive with other professional career choices. A lot of the evidence we heard earlier is that nursing compares unfavourably with other professions. Is this additional training you talk about part of this market approach or is it something else?

Ms de Silva—The marketing approach is trying to attract new people into nursing.

Senator TCHEN—Can you expand on that, please?

Ms de Silva—The marketing approach?

Senator TCHEN—Yes.

Ms de Silva—Yes, that is actually addressed here and that is one of the recommendations that has been put forward to the state for senior nurses and other appropriate people to start working on how we market to schools and mature aged men and women who would like to get into nursing.

Senator TCHEN—So it is marketing in terms of recruiting?

Ms de Silva—Yes, that is right.

Senator TCHEN—Recruiting into training?

Ms de Silva—Recruiting new people into nursing.

Senator TCHEN—It has not started yet?

Ms de Silva—No. It is one of the recommendations here.

Senator TCHEN—You also mentioned that it may be time now to consider a common curriculum for all health professionals. Is that just an idea at this stage or is it a matter of discussion?

Ms de Silva—It is an idea. I believe there are some lectures at early stages, which are shared by pharmacy and medical students. That is the kind of thing we are looking at in the future.

Senator TCHEN—The idea then is to bring the nursing profession up to the same level of status and training as the other professions?

Ms de Silva—That is one of the ways of doing it, to actually share ideas and commonalities within the health professions.

Mrs Crowder—The University of Tasmania has actually set up the School of Health Sciences which incorporates medicine, nursing and other health professions, so you can actually use lecturers across the board. The lecturers can actually share common curricula and participate as a group, not just distinctly for doctors or nurses.

CHAIR—For how many years?

Mrs Crowder—It depends on the subject. I do not think there is any formalised type of thing at the moment. I know they do share lecturers. That is the level it is at now. They are looking at developing common core subjects that health professionals can do as a group.

CHAIR—Some 25 years ago, I taught at Flinders University, with medical students and nurses in the one class, so we are very pleased to find that other people are now following this idea.

Mrs Crowder—And it worked well?

CHAIR—It did. I couldn't insist it is still the case. I understand something similar is happening there and at Newcastle. I think Flinders and Newcastle were the innovative schools across the country.

Mrs Crowder—There are lots of subjects that could be—

CHAIR—It is a very interesting point.

Senator TCHEN—Ms de Silva and Mrs Crowder, are you able to explain some of these issues raised by Family Child and Youth Health Services in their submission?

Mrs Crowder—We can try but we cannot guarantee anything.

Senator TCHEN—Related to your suggestion about a common foundation in the curriculum, the Family Child and Youth Health Service in their submission recommended:

> A two-tiered nursing structure for the performance of generalist nursing functions.

Really carer functions, because the lower level basically is just the very traditional type of nursing work. Can you explain this recommendation? Are they talking basically about just trying another way of regulating those people who are not regulated at the moment?

Mrs Crowder—Not knowing about it, I cannot speak to it. I do not know whether they are talking about the EN/RN, in which both are regulated in this state, or whether it is carer versus

RN. I am not sure whether it is a third tier they are talking about or whether it is the EN/RN or the carer versus RN.

Senator TCHEN—If I may quote this to you, the recommendation is:

A two-tier nursing structure for the performance of generalist nursing functions. One nursing role would be oriented towards hygiene; feeding and assisting patients/clients attend to basic living needs when the patient/client is unable.

It seems to me that that is really the role of the carer because that is actually trying to extend the nursing function downward. When you talk about the training curriculum you are extending it upwards. Is that a bit of a dichotomy in the profession?

Mrs Crowder—Basically you could go across a spectrum. The TAFE program now is the certificate I to III—which covers that carer role and the certificate IV is the EN role through our TAFE system for—

CHAIR—Four what?

Mrs Crowder—They call it certificate IV.

Ms de Silva—It is the EN training.

CHAIR—What does certificate I get you?

Mrs Crowder—Certificates I, II and III are related to carer roles within aged care and the disability sector, where we have carers.

CHAIR—And EN?

Mrs Crowder—That is certificate IV.

CHAIR—Are these actually complementary? Can you do I, II, III and IV?

Mrs Crowder—You have to do I, II and III to do IV.

Senator TCHEN—So in I you get to feed people, in II you get to wash them—

Ms de Silva—With IV you might get to give medication. It qualifies you to be a hospital aide.

CHAIR—But I, II and III take one year, and then that entitles you to do the second year of a two-year EN course?

Mrs Crowder—Yes, I cannot tell you the specifics; that is a federal issue. The EN training through TAFE is—sorry, that is the state, not federal, it is around the other way. It is through education that we do it so I am not an expert on it. You could then go the other way. If you talk about tiers within RNs, you do five years and become nearly a doctor. There is the whole spectrum.

Senator TCHEN—Is that a matter of concern? I am not sure how the nursing profession people see it, but maybe the department has a different view to it because the department will be keen to regulate those people who are not regulated at the moment.

Ms de Silva—That is certainly a contentious issue, whether to regulate what is known currently as the unregulated. It is such an awkward title but that is an issue everywhere we have been and with everyone we have spoken to. What do you do and how do you regulate? Once you regulate that category of worker then where does that fit into the tier of nursing?

Senator TCHEN—What is the department's view?

Ms de Silva—Certainly there is a need to review what registered nurses do to define the scope of practice so that it is in line with the expectations of someone who is going to university to invest three years of study. Anecdotal evidence suggests to me that many of them do not want to be involved with what they see as the personal basic task. Whilst they understand that that is all part of patient care there is also that issue of how much they get involved with the personal basic care when there are other tiers such as the EN perhaps. We can have more responsibility working side by side with the registered nurse to deliver that personal care.

Mrs Crowder—Regulation, as I understand it under our act et cetera, is basically there to protect the public, and for the public to be protected we need to know what the registered nurse might do or the medical practitioner might do or whatever. Basically it is an issue of whether we need to regulate or whether they are under the supervision of other health professionals who are being regulated now. It is looking at why regulate.

Senator TCHEN—I understand that the department recently negotiated a new nurses enterprise bargaining agreement. The larger part of it is the 12½ per cent increase in salary to bring it into parity with the other states. Has it had much of an impact in terms of retention rate?

Ms de Silva—Certainly it has been useful when we recruit people from elsewhere to be able to say, 'We've got a new EBA. We are in the middle of the pay rise, so there are two more to go.' That has been useful, but I cannot actually say that because of that we have had a whole—

Senator TCHEN—So the rate of outflow has not markedly changed?

Ms de Silva—It has been stable and for similar reasons.

CHAIR—What about those parts of the EBA that are not yet being implemented? They will be?

Ms de Silva—Certainly they will be.

CHAIR—Earlier witnesses today have told us that they are a bit concerned about some of the parts of the so-called EBA. They said they are so-called, but 'we have not seen any money and what we thought was a commitment to proceed, does not seem to be proceeding.' Could you comment on that?

Mrs Crowder—Basically, as the EBA is written, it is all being followed. There is nothing that is not being pursued as written in the EBA. So, for example, the staff skill mix is being dealt with through committee. It may not be moving as quickly as they would like, but it is moving as per the instructions of the EBA that are written down.

CHAIR—If those witnesses came back we could say, 'There we are. We put your questions to Mrs Crowder and Ms de Silva, and they assure us, on behalf of the department, that all parts of the EBA are in process. Nothing is being stopped, but some things seem to be taking a long time.'

Mrs Crowder—Yes, that is right.

Ms de Silva—Yes, because they are working through various committees—for example, the acuity and nursing hours. Currently the committee is looking at the Western Australian model and the committee is a multi-sector committee, as in unions, departmental and so on. Again, that is a big issue, but it is being looked at. The preceptorship allowance has been implemented.

Senator TCHEN—What exactly is the amount of the allowance?

Ms de Silva—The preceptorship allowance is one dollar extra an hour for whoever is the preceptor, and that was negotiated. That is the person who is preceptoring a new graduate or a re-entry person.

Senator TCHEN—That is almost like a peppercorn rent, sort of honorary.

CHAIR—That is right. Is that the best that the profession could extract?

Ms de Silva—Yes, and the EBA is something that was not just one group. Certainly, they came together to come up with something like that.

Senator TCHEN—Is that regarded as adequate, or is it just that people want to have the idea, the principle?

Ms de Silva—I guess it is the principle of being recognised for being the leader or the teacher.

CHAIR—What did they ask for, Ms de Silva?

Ms De Silva—I wasn't involved in the negotiations; I don't know.

CHAIR—Do you remember, Mrs Crowder?

Mrs Crowder—No, I don't. I do not know whether any amount—

CHAIR—I bet they didn't ask for a dollar an hour.

Mrs Crowder—I am sure they didn't, but I don't know the amount.

Senator TCHEN—Please understand we are not criticising the EBA.

Mrs Crowder—No, and I am not trying to justify it. I am just saying that, historically again, the different levels within nursing, the level 2 role under the career structure was a preceptor role and the extra money that was given was in recognition of that. We have found that the number of preceptors we need outweighs the number of level 2s that we have, so it really is—the adequacy of it I am not saying— recognition for their role.

Senator TCHEN—And the system is working well?

Ms de Silva—Yes, certainly they have to claim the allowance. So they claim it and so far I haven't heard anyone knock it back. They are quite happy to accept it.

Senator TCHEN—No, I do not mean that. I mean the output of the student, the student's qualities and so on, that part is working?

Ms de Silva—With all students who are preceptored, whether they are students or graduates, there are very specific outcomes that the preceptor has to achieve with the student. That is working well in that respect.

CHAIR—We have been told something different from that. Not that I would want to say specifically that it is in this hospital in this part of Tasmania, but certainly the evidence earlier today would suggest that in Tasmania we have the same problem as we have in other parts of Australia. It is that there are nothing like near enough preceptors, that if you have 20 recent graduates hit the ward one preceptor is absolutely not enough, certainly when it comes on top of your own clinical duties—because if you are not a level 2 you really ought to be or you are doing a fair amount of the administrative and supervising role. We hear that there are not enough. You both nod in agreement: is that because you know that to be the case too?

Ms de Silva—Yes. We are consistently training them, so we offer a clinical associate program and anyone who has any desire to become a preceptor, to pass on their knowledge, can join up with the clinical associate program as a prerequisite and then they do the preceptor program.

CHAIR—Why haven't you got enough, Ms de Silva?

Ms de Silva—For different reasons. Sometimes people do not feel that they are confident enough to want to impart their knowledge to someone else; they are still learning themselves. We certainly have to encourage others to apply. There are some shifts where there are enough for everybody, but on some days, because of rostering and skill mix, there may not be enough.

CHAIR—Do you have any limit on the number of students for whom a preceptor should be responsible?

Ms de Silva—Certainly. The university also puts a limit on it. They do have ratios. That is at undergraduate level, but for preceptorship I am talking more about the graduate level.

CHAIR—Are there any limits on the number that a preceptor should be supervising?

Ms de Silva—Usually it is a one-on-one thing, so the preceptor for that shift will usually only have one person who will shadow him or her, and that is part of their learning.

Senator TCHEN—It is mentioned in the written submission that the Commonwealth could assist by ensuring adequate placements at university and TAFE colleges for nursing training. Can you make some estimates of what an adequate number of placements is, because a university probably wants as many as they can get.

Ms de Silva—In this report we did a modelling exercise on what is required. We used a model based on a South Australian model. They may be pie in the sky numbers, but it is certainly in this report. There is the best case scenario: in 10 years time, how many nurses would we need? How many university places are needed? There is also the worst case scenario, and the middle case. That report needs to be debated, examined and analysed by the university and the department, but it has been put forward as a model. The department engaged someone in South Australia; we used his modelling technique. That is not to say it is the best; it is just one of the models available.

CHAIR—Of course it is the best!

Ms de Silva—Sorry, it is the best. So the answer is that it depends on whether we have got a low scenario, high demand or a middle one.

Senator TCHEN—What about the nursing services in remote and—I am told that the whole of Tasmania is a regional area—rural areas? Does that pose a special problem?

Ms de Silva—I gave Queenstown as an example, and Senator Crowley and I were talking before we came in here. It is very difficult to predict because, for example, on King Island some months ago you could not get a nurse for anything, but now there is supposedly a waiting list for people wanting to go to King Island to work.

CHAIR—Why?

Ms de Silva—That is what we need to find out—what changed for that to happen.

CHAIR—What changed according to an earlier witness was that they were offered their to and fro airfares.

Senator TCHEN—Two trips a year.

Ms de Silva—That could be the case. That would be a local management decision.

CHAIR—You did not know that? It is a very interesting thing but it would also seem to me important that that information be provided to people like yourselves in the planning area, because if two trips a year are paid for—is that right?

Senator TCHEN—From the states of origin.

Ms de Silva—To their home base.

CHAIR—We do not know where they are from; it may be the mainland. It would seem to me that that is saying that if people who go to work in isolated areas, or areas that are a bit away, have a clear understanding that they will be able to get home a couple of times a year, then it is a case of saying, 'Whacko, let's go over to KI and try it.'

Ms de Silva—With other rural areas such as Queenstown it has always been difficult to recruit. One of the strategies we have to look at is whether we start offering incentives for people who wish to go to Queenstown. Maybe we should not even recruit them permanently but look at some way of involving urban nurses who are able to go elsewhere on a short-term basis and give them some kind of incentive. Maybe they could go to Queenstown for three months and get an extra week's leave or something like that. That is the sort of thing we are looking at.

CHAIR—Is there a hospital in Queenstown?

Ms de Silva—Yes.

CHAIR—How many beds?

Mrs Crowder—There are 10 aged care and acute. The average occupancy of the acute beds is about six. I think they have a lot more than six but their occupancy level is about six.

CHAIR—Public or private?

Mrs Crowder—It is all public, and the aged care beds.

Ms de Silva—Many of them come to the Royal Hobart Hospital for treatment and they go back there for convalescence.

CHAIR—I am not sure that you answered Senator Tchen by giving an estimate of how many places. If you did, I am sorry.

Ms de Silva—Yes, I referred to this document. There are numbers here for low, high and middle demand.

Senator TCHEN—Actually it was a bit of a rhetorical question.

CHAIR—Do you know whether you were asking for the same numbers as the university?

Ms de Silva—More.

CHAIR—You were asking for more?

Ms de Silva—Yes.

CHAIR—That is interesting.

Ms de Silva—That is why I said it needs some debate but it is in this document which is available to everyone.

Senator TCHEN—I understand that an earlier witness told us that the university actually has an additional 15 places more than in previous years.

Ms de Silva—Yes. This is projecting forward five or 10 years. It is a number that is more than what is being offered today.

Senator TCHEN—Do you put in the retention rate as well when you make your estimates? If you train, say, 200 and 199 then depart to the mainland—

Ms de Silva—Certainly, the model, while it is a linear model, does take into account attrition rates as well.

CHAIR—What do you have in place to tick-tack between health, which is a state matter, and nurse education, which is a federal matter?

Ms de Silva—We have the partnerships in health agreement.

CHAIR—Please explain what 'partnerships in health' means.

Ms de Silva—It is an agreement between the department and the university to look at ways in which we can improve outcomes for health.

CHAIR—Who meets? Is it you or a senior designated—

Ms de Silva—Senior staff from both the university and the department.

CHAIR—What do you mean by 'senior university staff'?

Ms de Silva—Professor Carmichael, who is the head of the school, various faculty heads and representatives from the public sector.

CHAIR—Is that the head of nursing? Do you have a chief nurse?

Ms de Silva—Yes, 'principal nurse adviser' is the title.

CHAIR—Since when?

Ms de Silva—Since early last year. Before that we had a chief nurse but there was a hiatus when the department was deciding about what to do with the position.

CHAIR—A very big hiatus, yes. As you said before, Ms de Silva, all those things we used to have that got deleted are now being replaced. How often does this partnership between state nursing and federal representatives meet?

Ms de Silva—I think they meet at least four times a year.

CHAIR—What are the main items on the agenda?

Ms de Silva—Issues like what to do with postgraduate nursing education, how to train our preceptors—those are the two things that I can think of.

Mrs Crowder—We have lots of conjoint appointments.

Ms de Silva—Yes, what to do with conjoint appointments.

CHAIR—I am not sure that 'conjoint' is not tautology; but never mind, I rather like it. How are these conjoint appointments agreed? Is it a university appointment or is it a nursing appointment?

Ms de Silva—It can be either. It is more the percentage, whether it is 60 per cent university and 40 per cent hospital.

CHAIR—So when you, Ms de Silva, say, 'I think this person is good enough to teach,' does the university accept your word on that?

Ms de Silva—It is the position. It is a teaching clinical role. It is agreed as to what percentage is university and what percentage is the hospital and then it is advertised as such.

CHAIR—Who decides what percentage is sufficient qualifications? I presume you do not put anybody in.

Mrs Crowder—No.

Ms de Silva—It is based on the position.

Mrs Crowder—Yes.

Ms de Silva—It depends on what the role is.

Mrs Crowder—You decide what the role is and what they require and then it is advertised and appointed at the level required.

CHAIR—Can you give me an example of a conjoint appointment?

Ms de Silva—For example, the professor of medicine is a role that has some duties associated with clinical and some with the university. That would have had some discussion as to—

CHAIR—How much university teaching is now happening on hospitals?

Ms de Silva—Quite a lot because it is co-located with the clinical school. This teaching hospital is anyway. Certainly Launceston General too has a large proportion of undergraduate medical education that occurs there.

CHAIR—Are you campaigning to get a university campus in Hobart?

Ms de Silva—The nursing component of it?

CHAIR—Yes.

Ms de Silva—It comes up from time to time but I do not know that there is an active campaign. There certainly is not at the moment.

CHAIR—If our report recommended that, what would you say?

Mrs Crowder—It would be advantageous.

Ms de Silva—It would be advantageous particularly for Hobartians who might wish to take up nursing but for various reasons cannot leave their families or cannot afford to live elsewhere.

CHAIR—We have had a number of people tell us exactly that. You know better than I about the difficulties in wanting to do nursing but having to leave here and go to Launceston. For some people that is easy but for other people it is a problem.

Mrs Crowder—They can do a lot of their second year in Hobart and all of their third year in Hobart. In reality they are doing their first year in Launceston, and some of their second year they need to be in Hobart. It is not for the whole three years.

CHAIR—But you are having them away for the youngest of those three years when they are probably less able to—

Ms de Silva—Fend.

CHAIR—fend for themselves. Also we have been told that one of the problems is that in Launceston there are not nearly enough part-time jobs, which university students depend on to support themselves. You both nod. Just for the record, the witnesses nodded yes. That is an important consideration. In the light of that, would you care to comment on what is happening, I believe, here and in some other places; that students are able to work in a clinical situation which is giving them a kind of experience and a feel for the culture of the hospital but it is creating concerns in that they are seen sometimes to be just another staff member when they are just not qualified? They are probably not even EN qualified. How is this being managed? How is it that students get to work? It is clinical experience but it is concerning.

Ms de Silva—I understand. Currently we know there are undergraduates who work in the non-public sector. I know they work in aged care in nursing homes doing weekend shifts and so

on. There is not yet a category of employee—let us call it the undergraduate nurse employee. I know what is happening in South Australia and in Queensland and we are looking at it here. It was a point that was raised at the recent national nurse education review. The team was here a few weeks ago and we talked about that. Certainly the unions have also been involved as to how we can best utilise the undergraduate nurse to give them that exposure as well as employment.

CHAIR—Do you know what kind of money they are getting?

Ms de Silva—I believe in South Australia it is about $12 an hour.

CHAIR—I have been told that one of the problems with it is that lots of girls would prefer—I mean nursing students, men and women—not to work in that situation because it pays much less than, say, Kentucky Fried Chicken?

Ms de Silva—Yes, working in Myer or Kentucky Fried Chicken.

CHAIR—Is that the case?

Ms de Silva—I do not know at this stage. We have not gone that far yet. It is on the table as one of the issues that this state is going to look at—the employment of undergraduate students. First of all we have to see what it is we are employing them for. If it is optional, how does that affect their clinical placement later on in their course? Also, what do we pay them, what category are they and so on?

CHAIR—Please say if it is not possible, but in times past girls, in particular, would leave home and live in a nurses home. They would be a first-year nurse, a second-year nurse and then a third-year nurse. They would be under the supervision of the matron in charge of that ward and they would go to their lectures after work, usually in the nurses home. Would you be able to find any evidence of comparable pay scales—and I do not want you to go back 50,000 years or take a lot of time to do it? In the case of a student nurse, a single striper now, do you employ single stripers or do they have to be double stripers, in old-fashioned language?

Ms de Silva—Second-year students.

CHAIR—If you are taking second-year students and not first-year students, would what they are paid be comparable in any kind of way to what would have been the wage scale back then?

Ms de Silva—It would be interesting to look at that. I remember getting $36 a week as a first-year student.

CHAIR—If that is not a major exercise, if someone could send us a piece of paper on that, that would be interesting. In some ways the nurses back then were actually students under supervision. What you would be concerned about is whether, if the students are working, they are working as low paid or students under supervision and whether there is really any supervision if they are there doing holiday fill-in jobs.

Ms de Silva—That is what I meant about what we are employing them for. Is it for their benefit or for ours? In days gone by, accommodation cost them hardly anything, so what we are paying the students now would be very important in terms of how they sustain themselves.

CHAIR—On the very last line of page 5 of your submission you say:

In some areas educational requirements to enter nursing have dropped in order to encourage participation.

Do you know where that is?

Ms de Silva—That is what I have heard from elsewhere. For example, at chief nursing officer forums, we have been told that some universities have actually dropped their entrance levels in order to get the numbers. But in the last couple of years I believe that has not needed to happen because of the higher demand.

CHAIR—If you could point the committee to any evidence of that, it would be appreciated. If you cannot, just let us know. If you can, give us a pointer to it because I certainly know that over the years universities have been upping and downing the entrance figures for science, for example, and for education, but I have not been directed to that kind of evidence for nursing to this point.

Ms de Silva—I can say with certainty that I was at a meeting recently attended by a senior Victorian academic and we were told that as well, just in conversation.

CHAIR—What is ‘tissue viability’? I understand ‘health professionals working in specific contexts such as infection control’. I think I understand ‘continence’—I think it refers to bladders, not alcohol. What is ‘tissue viability’? You mean stopping them getting bed sores?

Ms de Silva—I think it is wound care specialists. That is a growing field of nursing.

CHAIR—I am screaming for this profession to use language that any of us can understand. On page 9 it is stated that the alternative models of nurse preparation are, for example, offered through Notre Dame and the universities of Wollongong and Flinders. What are they? Can you tell us that in one minute?

Ms de Silva—I believe the University of Notre Dame’s system is that the university actually has a relationship, like a partnerships in health thing but with a particular hospital or hospitals, and only with that hospital or hospitals. So there is that relationship from the beginning and they—

CHAIR—Do Wollongong and Flinders have that too?

Ms de Silva—I believe that is a similar sort of model but Notre Dame is the one I know of.

CHAIR—Would you care to comment on its value, because we have had raised by others that now universities produce the places and the students can be allocated to a number of institutions, so they are no longer saying, ‘I am a St Vincent’s Hospital graduate’ or ‘I am a

Royal Hobart Hospital graduate,' but they are certainly not saying, 'I am a Tasmanian University graduate'—not at this point. Do you know?

Ms de Silva—As far as allocation goes here, it does not really impact that much on us, but I would imagine that in places like Victoria and New South Wales there are some benefits in being associated with one particular hospital, in terms of 'That is where I am going to go to do my postgraduate' et cetera.

CHAIR—In times past it was reputation.

Ms de Silva—Yes.

CHAIR—If you graduated from St Vincent's Hospital or the Royal Melbourne in Melbourne, for example, you were known as a class nurse, and you were fought over around the world. You sailed into all sorts of places. Is that still the case? If you said you were a University of Notre Dame nurse, would people say, 'Wow, we have to have you'?

Ms de Silva—No, I could not say that for sure.

CHAIR—You do not have any sense of that? If you get a whiff of it, let us know, because I think that is one of those things about the recognition of professional standing. For instance, would you prefer to have nurses from the UK or Canada?

Mrs Crowder—I think that is the level it is at now, because I know Australians are very highly valued in the UK, whereas West Indian nurses et cetera—you know, there is a pecking order.

CHAIR—It is all right; it is all on the record, Mrs Crowder; it does not matter whether you whisper it.

Mrs Crowder—There is a pecking order.

CHAIR—There is a recognition, is there not, that Philippine nurses are very sought after? They are described to me as very good with the tender, loving care. People really love them because they care for people in an old-fashioned way. That is, they are good at hands-on care and so on.

Ms de Silva—The traditional way.

CHAIR—But certainly Australian nurses have a reputation around the world, and I am not sure whether that reputation is yet sheeted home to institutions—whether South Australian nurses are better than New South Wales or whatever.

Ms de Silva—I do not think that nursing in universities has been going on long enough to actually develop that kind of culture.

CHAIR—That is interesting. It would be interesting too to see whether an attachment to a particular hospital or health institution gave you the flavour—

Ms de Silva—That will come in the future.

CHAIR—when the university may not. But I think the eight sandstone universities are desperate to hold on to their standard as better than the rest.

Ms de Silva—Yes, what they call the ‘brownstone universities’—the older, established universities.

Senator TCHEN—You mention Notre Dame here. I assume their model of nurse preparation is a very good model.

Ms de Silva—It is a model which attracts some people. I am sure you will find supporters and detractors of that model.

Senator TCHEN—I would be interested if you can find anything about the reputation of that course, because one of my colleagues, Senator Carr, was going berserk a few months ago about Notre Dame not being a university of good standard.

Ms de Silva—A university of?

Senator TCHEN—Well, he claims the university was a ‘fly-by-night’ university.

Ms de Silva—Yes, it is all fairly new, even this concept of developing that relationship.

Senator TCHEN—I would be interested to hear someone from the professions say that that university is actually of a very good standard, and I will show it to him.

Ms de Silva—It has been written up in a couple of nursing journals.

Senator TCHEN—If you can find them, I would be interested in getting them. Thank you.

CHAIR—Lots of witnesses have asked for national curriculum, national registration.

Ms de Silva—One registration, one curriculum, yes.

CHAIR—Are you in sympathy with that?

Ms de Silva—Not specifically, because we made representation to the nurse education review and that came up as well. I do not know that that is entirely achievable. There has to be some diversity, I think, in a profession like nursing, medicine, whatever.

CHAIR—If there is some diversity, does a wage diversity follow?

Ms de Silva—Then it is only because one university would offer a better standard than the other, if there is going to be this sort of wage diversity. This is my personal opinion now. I think we should be encouraging some sort of diversity rather than one national curriculum for everybody. Certainly there are some standardised aspects that have to be included, the core curriculum, but for the rest of it I think it depends on what is important in that particular state, area or region.

CHAIR—It is an interesting question because other witnesses have raised with us that, if you wanted to move from Tasmania to Victoria to work as a nurse, the best ticket you have got is your Tasmanian nurse registration. They will perhaps ask for some other evidence but, particularly if you have your registration from Tasmania, you can pretty easily expect to get registration in Victoria. If you can do that across the country, is it not reasonable to expect that there should be some kind of similarity between what you are registering for?

Ms de Silva—Yes, so that is where that core curriculum is, but not a standardised curriculum for all nursing courses.

CHAIR—Would it necessarily mean that, Ms de Silva?

Ms de Silva—I do not know. For me, when they say standardised national curriculum, I have this vision of just one type of course. But I think there should be some diversity within the core curriculum.

CHAIR—I think the point you make is good. There is sympathy from other witnesses; people wanted some comparability. I do not dare to say that!

Ms de Silva—Portability?

CHAIR—No. Some way in which what you were doing as a nurse—and, for instance, if you were registered in South Australia—your skills would be comparable to what you had been registered for. There would be no major difference in terms of skills or ability. If South Australia employed nurses from Victoria, we would not have expected the state of nursing to drop through the floor, to put it in an interesting way.

Ms de Silva—The way things are in health now, I think you would employ nurses as long as they are registered. It does not matter which state or university they come from; isn't that right?

Mrs Crowder—That is right.

Ms de Silva—We need them all.

CHAIR—You do not know whether some are better than others?

Ms de Silva—I do not know that any state is better than any other. Certainly as an employer, as someone who interviews people and so on, I would not be looking at exactly which university they went to nor would I be saying, 'This is not as good as that one; we will pick her.'

CHAIR—That is probably a very useful point to finish on, the time being pretty much where it is—the idea that, whatever else we can say, Australian nurses enjoy an excellent reputation around the world and with a fair amount of reason. Really, there is not much difference in the nurse education or the quality of nurse that is produced in one part of Australia compared to another.

Ms de Silva—I would agree with that.

CHAIR—So we can say to the nurses, ‘Go shopping.’

Ms de Silva—Yes, but come back.

Mrs Crowder—Yes.

CHAIR—On that note we will close. Thank you very much indeed.

Committee adjourned at 4.32 p.m.