COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Reference: Nursing inquiry

FRIDAY, 22 MARCH 2002

SYDNEY

BY AUTHORITY OF THE SENATE

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Friday, 22 March 2002

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

Substitute member: Senator West for Senator Gibbs

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

Senators in attendance: Senators Crowley, Knowles, Lees 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.

WITNESSES

Committee met at 9.03 a.m.

BRODIE, Ms Patricia, President, New South Wales Midwives Association

DAWSON, Ms Jennifer Anne, President, Association of Neonatal Nurses of New South Wales Inc.

KENT BIGGS, Ms Joanna Mary Bridget, Secretary, Australian Neonatal Nurses Association

SIMS, Ms Linda Jean, Executive Member and Director of Finance, Australian College of Emergency Nursing Ltd

ONLEY, Ms Julienne Lesley, Manager, Policy and Professional Services, Australian Nursing Homes and Extended Care Association (NSW)

CHAIR—The Community Affairs References Committee is continuing its inquiry into nursing. I welcome representatives of the Australian Nursing Homes and Extended Care Association, the Australian Neonatal Nurses Association, the Association of Neonatal Nurses of New South Wales, the Australian College of Emergency Nursing and the New South Wales Midwives Association. The committee prefers all evidence to be given in public, but should you wish to give any of your evidence in camera, you may ask to do so and we will give consideration to your request. The committee has before it your submissions nos 893, 439, 712, 813 and 891. Do you wish to make any alterations to those submissions? I will ask each of you to make a brief opening statement and then field the questions from the senators. I appreciate your coming as part of a panel. It is not quite the same as being single witnesses, but we wanted to give as many of you as possible the opportunity to speak to your submission.

Ms Onley—The Australian Nursing Homes and Extended Care Association of New South Wales is very pleased to be invited to give evidence today. We have a current membership of approximately 350 facilities representing about 29,000 beds in New South Wales and the ACT and many of our other members and associates represent significant numbers of self-care facilities, community service providers, and people whose expertise and knowledge of aged care is well respected. I refer you to our submission of July 2001. I will not reiterate the points we made in that submission but I will explain a little bit further our perspective and the relevance of that submission for the benefit of the committee members who are here today.

I am representing the members of ANHECA New South Wales that are, for the most part, providers of aged care across private enterprise, church, charity and the community sectors. I would like to briefly describe the process we went through in developing our submission to ensure you know it is fully representative of the nurses who work in our sector. Also, I would like to establish my own credibility as a spokesperson for those nurses. Very importantly, I will update the statistics we quoted in our submission to present a contemporary profile.

The development process, firstly, was in several phases. We aimed at attaining a representative view of all nurses working in the aged care sector amongst our member facilities. It was a very robust consultation process. We encouraged nurses and other members of our association to actively submit all their views and opinions and to take part in informed discussion and debate over a period of a month or so. They were given every opportunity to

contribute constructively, and many of them did so. We also used focus groups with structured discussion points, analysis of their discussion, and other contributions, and then we circulated the consolidated penultimate document amongst all our members and incorporated their input as well. We consider that our submission was an honest and considered reflection of the views of the membership.

As for my own background, I am a registered nurse and I have graduate qualifications in aged care nursing and a master's degree in science, majoring in mental health. I have worked in and around the aged care sector for many years since the early 1970s as a clinician, manager, consultant and an educator, and I have represented nurses at many and varied committees at all strata of government and other organisations. I am a fellow and a board member of the New South Wales College of Nursing and my position at ANHECA New South Wales—we are very fortunate at ANHECA to have this position—is manager, policy and professional services. A prerequisite of that position is that I am a registered nurse. I coordinate the ANHECA New South Wales Nursing Issues Advisory Committee and the federal committee of the same name. I act as a resource person in professional policy matters.

Most importantly, thirdly, to highlight the trend of increasing acuity in residents in aged care facilities throughout Australia, I will, as I mentioned earlier, update the figures we have which are provided three monthly by the Department of Health and Ageing. We showed those figures in our original submission. That data revealed a steady increase in residents in category 1 which represents the highest level of need in both nursing homes and hostels—and I use the old terms so that we are all quite clear. This same trend over a period of four years has been noted in the two-year review of aged care reforms by Professor Gray. Further data just available shows the trend is continuing. In fact I have figures from the quarter ending 13 December 2001—the latest available to us—and in Australia at this date there were 806 residents classified at category 1, the highest level of need in hostels. That was up from 620 some nine months earlier, and there were 23,153 in nursing homes, up from a previous figure of 20,890.

A similar picture emerges for residents in category 2, the next highest category of need. This steady continuing increase in the acuity and dependence of residents adds weight to our argument for higher funding for skilled nurses in the residential aged care sector. To conclude, I appreciate this opportunity to appear before you and would like to be able to expand or clarify any points we made in our submission.

CHAIR—Thank you. Would a representative of the Australian Neonatal Nurses Association like to make an introductory statement?

Ms Dawson—Thank you for giving us the opportunity to speak with you today. Some of the issues we would like to draw your attention to are staffing in neonatal nurseries, the importance of the role of education staff, funding for specialty nursing practice, and clinically relevant programs. On the issue of staffing we are concerned with management practices where only the number of nurses on a shift are counted. This type of approach does not take into account patient acuity and the knowledge and skills of the nursing team. When patient acuity is high there has been a trend to use education staff to fill in as hands-on clinical nurses. For short periods this may be appropriate, but it becomes inappropriate when used as a longer-term strategy to make up for a shortfall of experienced neonatal nurses.

We see the role of nurse aid educators, in particular clinical nurse educators, as pivotal to developing and improving clinical competence and in the recruiting of new staff and the retention of experienced staff. The availability of specialty education courses is a concern. Postgraduate level 2 and level 3 neonatal nursing courses are generally full fee paying courses. They are expensive, and may be out of the reach of many nurses. Our recommendation would be to increase the number of HECS funded courses and to develop courses that have flexible modes of delivery. Whatever the type of course, they need to integrate theory with practice.

Additionally, clinicians need to be involved in all stages of curricula development, teaching, supervision and competency assessment. We recommend increasing the number of joint clinical academic appointments. We recognise we are a small specialty group. However, our state groups work well together and we have been proactive in participating in addressing issues that affect our specialty and nursing generally. We have developed and promoted the use of standards for neonatal nursing practice and competency standards. We would like to table these documents for your consideration today. Thank you for allowing us to give evidence.

CHAIR—Thank you very much. Any comment from the Association of Neonatal Nurses of New South Wales?

Ms Kent Biggs—We have put in a combined submission because what the association of New South Wales reflects is exactly the same as the Australian Neonatal Nurses Association.

CHAIR—I thought that might have been the case, but thank you.

Ms Sims—Thank you for the opportunity to appear before you today, senators. It is interesting that we have several speciality groups today. I think it has been recognised that in the last few years nursing has become a very specialised field. One particular discrete speciality is emergency nursing. It has often been lumped with the generic term 'critical care' nursing or 'intensive care nursing' but in fact it has become increasingly obvious that emergency nurses are a little different, if I say so myself. We have to be fairly talented ladies and gentlemen in that we often see lots of different specialties and we have to be able to deal with all of those. We often see people in their sickest forms when they come in and we stabilise them before they go off to their particular specialties. In fact we really have to have quite a lot of highly skilled people to recognise and deal with all these people.

The Australian College of Emergency Nursing has the aim of standardising emergency care across all borders in Australia. We are currently undergoing negotiations with various universities whereby emergency clinicians will actually have input into curriculum development. It has often been the case where people felt that sometimes university courses were not totally relevant to their practical training. With clinical input into curriculum development we feel it goes much better and there is practical as well as academic influence in the pursuit of relevance in their education.

The other aspect of articulation with universities is the inclusion of some short courses that the college runs, sometimes as an essential element of post registration courses run by the universities or the universities have agreed to recognise these courses and give credit points towards a degree, if people go on to do that. As for the three programs we currently run, there is a course in trauma nursing, a course in emergency paediatric care, and a course in advanced

trauma nursing. These are internationally recognised courses conducted throughout Australia. Currently we are training approximately 70 to 80 trauma nurses per month and 30 to 35 emergency paediatric nurses per month—and that is Australia wide. Whilst these courses are very heavily subscribed—there is always a lot of interest—most of the nurses who attend these courses are totally unassisted, very few of them have study leave, and not many of them are funded in any way; they fund them themselves. We find that we do not have trouble attracting nurses to the emergency sector. We have a lot of new graduates and a lot of new people who are not experienced in emergency nursing and these short courses are very good in bringing their skills up to a level where they can work very effectively. In fact, funding from professional bodies that run particular courses in their specialties is as important as funding to professional educational bodies or universities. Certainly we find that with increased knowledge we increase job satisfaction and job retention.

Finally, the college aims to provide national competency based programs that allow for the transfer of skills between emergency departments across Australia. The group of experienced emergency nurses is run by a board. This has nurses from all areas of emergency nursing whether they are in education or at the practical level. We hope to fulfil the requirements of emergency nurses across the country. We certainly want to increase our programs to do that and we aim at retention.

CHAIR—We will now hear from the New South Wales Midwives Association.

Ms Brodie—Thank you for the opportunity to represent the views of the midwives, in this case across New South Wales. I understand that this is probably the only evidence you will hear that relates to midwifery but I guess some of the issues that are reflected here will have been reflected in other Senate inquiries, most particularly the inquiry into childbirth practices. So I appreciate that you may have heard some of this before.

With regard to the key issues to be addressed through the inquiry, I think it is now well known that there is a chronic and serious shortage of midwives in Australia and we would identify that as one of the first and foremost issues. That is subject now to a Commonwealth inquiry through AMWAC as a midwifery work force review. The consequences of these shortages are being felt right now in the community and in particular in rural and remote areas of the state and the country.

The consequences are somewhat invisible. We know that women will get on with their early parenting and mothering of their newborns and not necessarily demonstrate the morbidities that require re-admission to hospital or indeed chronic suffering. Certainly the consequences relate to, in some cases, the closure of services but also more commonly the situation where women are cared for during labour and childbirth by somebody who is not a qualified midwife. In fact, that can now be substantiated with the recent AMWAC data.

The second key issue is through opportunities to improve education for midwives. Again, we can say that midwifery is different. We have heard through the inquiry into nursing education that probably nursing education in Australia is recognised as some of the best in the world, but this is not the case for midwifery education. The standards have dropped considerably over the last 10 to 15 years. There are efforts being made to address that and I would recommend to you the current draft Australian College of Midwives National Standards for Midwifery, where the

college itself has attempted to develop standards of midwifery competence and practice in line with international standards. So that is some progress.

The other opportunity that is here now with us in Australia is the three-year Bachelor of Midwifery degree, which has already started through two groups of universities in Adelaide and Melbourne. We now have 150 Bachelor of Midwifery students enrolled. The profession recognises that as a significant step forward in raising the standard of midwifery care provided to women and also addressing the work force shortage. Certainly, there are hundreds on the waiting list for the next intake, which is expected to be in Sydney next year—the Sydney-Canberra Southern Cross Consortium.

With respect to other barriers and opportunities that are required to improve the educational standards, we would see there is a need for incentives and scholarships for indigenous women to participate in midwifery education. Of course, we heard earlier about the need to remove cost barriers in postgraduate courses per se.

The interface with the university and health systems is also another key area that affects standards and quality of care. There is a need for joint appointments across both the clinical and academic setting, in line with some of the medical systems that are in place. These seem to work well and we would recommend that those kinds of initiatives be developed. Some of them are being developed as one-off examples in some clinical academic settings.

Since the transfer to the tertiary sector, the role of the midwifery educator in the clinical setting has been somewhat let go. The assumption is that the university will do the clinical supervision, but there are concerns about the quality and recency of clinical practice for some of the academic teaching.

Issues addressing the retention of the midwives that we have are best summarised in the opportunity to work as a midwife and to be able to fulfil the role of the midwife for which we are educated. As some of you would have heard through the other inquiries, maternity services in Australia are increasingly medically dominated. The rising rates of intervention have consequences not only for the community but also for the profession of midwifery, so much so that, with the continuing escalation, the role of the midwife is becoming increasingly threatened and in some cases possibly even redundant. We see engaging with consumers as a strategy to address this. I request an opportunity to table what is still a draft and confidential—but which we have permission to give to you—combined effort of consumers and midwifery groups, called the National Maternity Action Plan. You will see over the next few months a concerted effort to pull together a strategy that sees the introduction and recognition of community based midwifery services. There is plenty of evidence and consumer support for that.

CHAIR—Ms Brodie, until when is the document confidential? If the committee gets it, do you wish it to be kept confidential?

Ms Brodie—It is currently available on a web site, through the Community Midwifery Program. It is a draft; it is not exactly confidential anymore. It does have ‘confidential’ written at the top, but we downloaded it from the web site last night.

CHAIR—So it is okay to accept it as a public document. Thank you.

Ms Brodie—We will be engaging more with consumers and, as that process continues and consumers become more organised and more educated, then we will start to see the visibility of midwifery, which is part of the challenge and the opportunity that we see in this inquiry. We know that, because it is a Senate inquiry into nursing, there was a significant absence of submissions about midwifery. I think you have already heard that we would have sought a Senate inquiry into nursing and midwifery and then you would have had hundreds more submissions from midwives.

I do have a couple of other documents that I request permission to table. One is a recently published paper into the contemporary issues of midwifery regulation, published in the *Australian Health Review*, which identifies some significant problems in the regulation of midwifery. The other is a paper that was forwarded to do with the indemnity issues facing midwifery in Australia at the moment.

Senator LEES—I thank you all for your submissions and I ask a general question, which is touched upon in here: what do you see as the major disincentives to encouraging people into nursing in the first place? Specifically for your specialty areas and for midwifery in particular, I am looking for barriers to looking at a midwifery course—although I understand at the moment that oversubscription is the problem because of the shortage of courses. But what are some of the problems, looking particularly at school leavers and getting them into nursing?

Ms Kent Biggs—I think the public perception of what nurses do is a problem. There is the perception that we are just basic carers, even though when people are asked they always perceive nurses to be the most honest and reliable people. They do not understand that we are highly skilled, well-educated people and that we are unique in that we are very compassionate and caring. There is a misunderstanding in the public arena about nursing.

Ms Onley—There is also a huge choice for younger people, for school leavers today, that was not there previously. At the time I left school and chose nursing, as my second choice of career—my first choice was teaching, until I saw the light—one could be, particularly a female, a teacher, a nurse or perhaps a librarian or, as I understand it, if one lived in Canberra, one could head for the Public Service as well. So there was very limited choice. Certainly that choice has broadened out. If you look at the range of courses that are offered at universities these days, it is very different to the range that was offered even 10 years ago. And nursing is competing. I concur with Jo Kent Biggs's comments: nursing is not promoted to the community as a profession with a huge standing. Certainly nurses are highly respected but often I feel because of that misunderstanding of what nurses do, and from the position of my own sector of aged care, if you tried to put a hierarchy of nursing, which some people try to do, we are fairly much down the bottom in terms of the community thoughts. We are regarded very much as giving basic nursing care. I prefer to refer to it as core nursing care. But still the perception is that anybody can look after older people, which we, sitting along this table, all know is not so.

CHAIR—Ms Onley, do you know of any part of nursing that is lower in public perception than aged care nursing?

Ms Onley—I can speak from the perspective of being a mental health nurse and a general nurse and so I am a combination of both.

Ms Dawson—The other thing is to do with starting salaries for nurses. Nurses coming out of degree programs are not on comparable salaries to other degree recipients. And you are never going to get away from the fact that nurses work unsocial hours, that people have family lives and that it is very difficult to organise your family life around working shifts that finish at 11 o'clock, starting again the next morning at 11 o'clock. It is much more difficult to organise your child care—all those sorts of things. We are never going to change that component of nursing: that it is 24 hours a day, 365 days a year.

Ms Sims—I was going to make a similar comment. I trained in the old-fashioned days when we were in the hospitals. You went into nursing as a young person and so shiftwork was just part of the deal and you grew up with that, if you can use that word. Now, because they are in universities—which we need to be of course—they work regular hours, they get used to regular hours and then all of a sudden they come into the hospital system and suddenly everybody is working shift hours. There are so many of the new graduates that I have heard say, 'I'm not working these hours; I'm out of here,' and there are three or four years training wasted.

Senator LEES—That was the question I was going to ask in a moment, about drop-out rates from all courses. It may be a bit early in the midwifery course to know.

Ms Brodie—You are talking about the current courses?

Senator LEES—Yes.

Ms Brodie—Certainly it varies from state to state, but with midwifery there is something like a 20 per cent drop-out rate, which is significant given the effort that one takes to get there. In the current Batchelor of Midwifery courses it remains to be seen. The retention rates are extremely high in the UK where now 90 per cent of midwifery education is through the direct bachelor route.

CHAIR—Where exactly is that 20 per cent drop-out occurring? Is it first year out?

Ms Brodie—It is first year out—not taking up the opportunity. In some parts of the country it is unfortunately because of lack of employment opportunity. We have got rural midwives doing their course but not being able to work in a rural hospital because they require postgraduate experience as they will be left on their own on the shift. So it is a vicious circle. It is a problem for rural midwives.

Senator LEES—We are looking at getting people in and then we have problems with drop-out it seems both during the courses themselves and at the end. In some places it seems to be even more in that first year out. What is your experience here in New South Wales either during the university course or at the time the new graduates face the real life of work?

Ms Onley—From the perspective of aged care, we have a very good program that many of our members and members of another peak body also belong to, and that is aged care career pathways. There we try to encourage new graduates into nursing, into our sector. We find that that program works extremely well; it is a very well-structured and well-mentored program.

Senator LEES—Does that have a lot of hands-on work, as opposed to theory?

Ms Onley—Very much so. It is very clinical in its focus. These are beginning nurses who have just graduated from universities. That program is very successful; it is small but it is growing at a steady rate. I can only speak for New South Wales and the ACT, although we have just received news that we have some members from Queensland who are taking part in that. So we are very happy with that progress.

As time goes on, we have an ageing work force. People are leaving our work force through the wish to retire et cetera. I am finding more and more in aged care—residential aged care, I am speaking about—that, because of the huge pressures placed on the nurses who work in that sector, mainly in the more senior management levels of the processes of mandatory accreditation and their perception of the documentation required for funding purposes, nurses are purely and simply burning out. We have our facilities through the first round of accreditation, and they get to a stage where they say, 'Our funding is dependent upon our documentation; we just have to do too much,' and they leave. That is burnout and it has been the case since 1977, since the advent of the Aged Care Act and its attendant principles. A huge issue is in the retention of experienced senior staff, let alone our problems of trying to encourage retention. With all due respect to my colleagues, we are all competing for the same small pool of nurses, trying to retain them in aged care—and, similar to every other field of nursing, we work very unsocial hours.

Senator LEES—Would anybody else like to comment?

Ms Brodie—With regard to midwives, the other issue upon graduation is the opportunity to work as a midwife, and it all depends on the model of care that is available in the local service. So we have midwives who are prepared to the full scope of midwifery, and they are limited in that they can only provide postnatal care, and in some cases labour care. But in many particularly rural areas again, they do not have any opportunity to provide antenatal care, or to meet women before labour. So they are disappointed and dejected and they do not stay.

Senator LEES—So, if you did a bit of a survey of midwives, you would come back with some very different answers in terms of job satisfaction. Those who are working as community midwives would feel that their training was for something, whereas others would feel that it is almost all over by the time they get into contact with mother and baby?

Ms Brodie—It is very much linked to—this is where midwifery or maternity services are different, as they primarily deal with healthy women—the model of care. It affects not only women's satisfaction with the whole experience because of the continuum but also the midwife's capacity to fulfil her role and her own satisfaction with her work. It is entirely linked to the model and organisation of care within that service. There is very good Commonwealth and state government policy recommending the new models of care, but the implementation is just not there.

Senator LEES—Is this partly because now in some rural areas doctors are pulling out altogether, anaesthetists are disappearing and women are being referred closer and closer to the seaboard?

Ms Brodie—Yes, and that is a major problem for rural and remote women. The unfortunate thing in this country is the failure to recognise midwifery as a key public health strategy. It is

still seen as an acute end of an episode of care that deals with a birth or a complication rather than a whole process of engaging with and meeting the women early in the pregnancy. We know that midwifery makes a difference to outcomes and cost, and still the model of care that is available is mostly still quite limited, apart from some excellent examples in half a dozen places in the country.

Ms Sims—In emergency nursing, there are two areas of drop-out. On one side are the new graduates, who come into a department all eager. As you know, emergency departments are increasingly busy—the acuity has gone up, as it has everywhere else—and so people are not being released for courses; they cannot get their study leave. So new graduates feel that they are not getting any education; they are getting frustrated because they feel they do not know what they are doing. It is so busy that it is very hard for a new graduate to cope with that pace. So a lot of them say, 'It is all too hard, I am going to go somewhere else.' I have heard a lot of my nurses say that they are going to aged care because it is much more relaxed.

Ms Onley—Until they get there.

Ms Sims—On the other side are the senior nurses who have been carrying the load for a long time. They keep getting all the new graduates in, start to train them and feel they are getting some support—that they are not carrying a lot of load because not everybody is totally skilled—then they see these graduates go again and finally you see your nurses get burnt out. There is an ageing population. I think the average age of emergency nurses these days is in the 40s, which is really quite old when you consider the acuity that you are dealing with and the pace that you are going at.

Senator LEES—I understand that you are seeing a lot of elderly people in emergency now. So how do the nurses' backs stand up to it?

Ms Sims—With great difficulty. Emergency departments are becoming very proactive in introducing lots of lifting machinery that we never used to have. Certainly they are working towards that, but it is still a lot of heavy work. What we are getting is burnout on both ends of the continuum, if that makes sense.

Senator LEES—Yes.

Ms Kent Biggs—Neonatal nurses are a very small specialty. Historically, we came through midwifery as most of us were midwives. It has only been in the last 20 years or so of the specialty—since JFK's son could not be saved and they talked about ventilation—that technology has assisted the sick baby. We now, obviously, try to attract nurses from midwifery and also from the paediatric strands. The delivery of a baby is a normal, healthy thing so most nurses do not think about a sick neonate. I have spoken to quite a lot of nurses who said they had no idea that this was a specialty area until they did midwifery in a tertiary hospital and there was a neonatal intensive care unit, which they were streamed into and they thought it would be a good idea.

We have a significant drop-out rate of new graduates; across the nation it is about 37 per cent in the first three to five years and they move on. This is combined with the 'old Turks', the nurses like Jennifer and I, who went into neonatal nursing and we are now either moving on

into higher or different positions. If you look around any department of health, it is full of very experienced nurses who have been streamlined into those sorts of organisations rather than staying in the clinical workface—that has a lot to do with the hours that people work. Those senior nurses are very tired and burnt out because they are having to maintain the high acuity of patients—a 500 gram or extremely ill baby can be quite horrifically frightening for a new graduate when they first step into intensive care.

Then we have the new graduates and we are being very proactive in recruiting them directly into the specialty. We are even looking at the undergraduates and we are getting them to come through and look at the neonatal intensive care unit. However, it is very complex as not only are we highly technological but also we are caring for the family as well as the baby in that transition from being seriously ill until it goes home, which can be quite a long period of time. Nurses just do not have the time when we are allocated seven minutes to help a mother breastfeed and you have a premature baby learning to feed for the first time. Nurses are saying, 'I have not got time to help that mother' and they get distressed because they are not able to provide the optimal care not only for the baby but for the family as well because it is a very intense area. For neonatal nurses, we have to be very careful that we support our new graduates by educating them. I think that is the fundamental thing. If you have an educated, well-supported nurse, they will inevitably stay because they feel that they are able to contribute to the wellbeing of that family group.

Ms Sims—I think that goes across all specialty groups.

Ms Dawson—Our specialty is slightly differently. Our average age group is a little lower; it is in the mid-30s. We have a lot of young women and some young men with families, so they have a lot of child-care issues that they are trying to sort out with working a rotating roster—which is the same for any nurse.

Senator LEES—I would like to move on to look at some of the solutions to the issues in each of the areas. I think midwifery has a whole set of its own problems on the status of the midwife and the models of care offered. As we look through each of the specialty areas, could you fill in on, firstly, how we can attract more people; and, secondly, how we can hang on to people? In other words, what are some of the solutions to actually reducing the average age of nurses to the mid-30s?

Ms Onley—Do you want to start with midwifery and the babies or at the aged care end?

Senator LEES—I think we will start at the aged care end.

CHAIR—How to sexy up aged care nursing.

Ms Onley—Indeed. Maybe I will come back to that one a little later!

CHAIR—While you are at it, sexy up mental health nursing?

Ms Onley—I shall do my best, Madam Chair. I would like to make a comment about the parity of wages, a factor that could very much increase the attractiveness of the residential aged care sector. We are not paid at a parity with our colleagues in the public sector. While I

acknowledge that this is a state and an industrial issue, it is a very important issue, I feel, for this committee to consider.

Senator LEES—I understand it is a Commonwealth matter as well in terms of the amount of funding from the Commonwealth.

Ms Onley—It most certainly is.

Senator LEES—I notice in your submission you have listed a number of other inquiries where this has come out. But it is very much a Commonwealth issue in terms of what the Commonwealth is prepared to give to aged care.

Ms Onley—I agree wholeheartedly, Senator Lees. We are constantly asking for a fuller bucket, or even perhaps a bucket that is overflowing. There are many reasons for that. One of them is that, with this increasing acuity that I mentioned in my statement first up, we acknowledge that we need to attract highly skilled nurses and we need the funds to more properly provide them with education and opportunities for development. There is no doubt that the funding in our sector is very, very tight. But that is a broad issue that probably goes way beyond just the nursing aspect of it.

I want to acknowledge how to keep people in our sector. This is very difficult. I have already indicated that we are competing with my colleagues across all specialties. The parity of wages is a fairly obvious point. The point was made earlier—I think it was made by my colleague from the emergency nurses—about people leaving that very busy sector and going into aged care to have a bit of a rest. As my colleague pointed out, that is until they get there and find out that it is not a rest.

We do have a minimal lift policy in place in all residential aged care facilities, so the bad backs are not so much an issue, but often that has been driven by the increasing cost of premiums for workers comp. The difficulties that we face in the clinical nursing aspects, apart from the management aspects that I mentioned previously, would not be so much the heaviness of our client group, because they are not all heavy. The biggest issue that would face them would be in the field of dementing people. Caring for people with dementia is, in itself, a highly specialised nursing skill. So we need to focus on that aspect in the hope of retaining staff who like dealing with people with dementia and who feel confident in the amount of resources they have and in their own ability and education to work with them. Another issue that we are seeing more frequently—and this is quite interesting because, in this state, it is seen as a Commonwealth-state impasse—is that we have an increasing number of younger acquired brain injured residents in nursing homes and hostels.

Senator LEES—Is that stressful for the staff?

Ms Onley—It is extremely stressful, because these people require different skills—skills that the aged care nurse usually does not have. These are skills that belong to the neurological specialty, the rehabilitation specialty and the spinal injury specialty. We are working very hard across the sectors to transfer those skills to work in models so that we can share skills, education and resources.

CHAIR—I do not wish to be a total interrupter of the line you are taking, but Senator Lees asked you to tell us how to encourage people into this area, and you are giving us a litany of why they should not go there. Would you have an advertising campaign? Does anybody in aged care nursing like it? Could you market it with the one person left who really enjoys it? I am seriously saying that I understand, and the points you are making are very useful for us, but I presume there are people who do enjoy working in this area. How can you encourage others to know that?

Ms Onley—I apologise for being a little bit roundabout. I was getting to that, Senator. The education and development opportunities have to be an enormous incentive for nurses to stay in the profession, and I think that has been shown in the various inquiries that I referred to in my submission.

Senator LEES—Could I take you a step further. In Victoria, I understand there are around 300 or 400 young people in nursing homes where there is no appropriate accommodation. If there is an issue about looking at a specific type of facility, it may end up being one of our recommendations to take the pressure off the nurses in nursing homes that have started to see one, two, three or four young people. Have you got any idea of the numbers in New South Wales of young people who are, say, under 50, who are now in nursing homes due to neurological problems?

Ms Onley—I did have those figures about two weeks ago, but I cannot recall the exact number now. It is around two per cent.

Senator LEES—Could you pass those figures on to us?

Ms Onley—Certainly. It is around two per cent, but it is not so much an issue of numbers but of the intensity of need and the inordinate number of complaints that we have to deal with that emanate from them and their representatives.

CHAIR—I think we could stay with each one of you and hear much more, but could we ask each of you: how are you sexying up your part of the profession?

Ms Dawson—As a neonatal nursing group, we are probably lucky in that babies are small and cute. That helps quite a lot.

CHAIR—Lifting is not a problem?

Ms Dawson—No, it is not; but moving equipment is, so you cannot put all the back-injured nurses in neonatal nursing so that neonatal nursing will be well staffed. That would not quite be true. But we have participated, as a specialty and a profession, in things like the Royal College of Nursing, Australia expos, where they take nursing out to the community and provide a venue for lots of specialty groups to promote nursing, show people what we can do and what the different specialties are like. In neonatal nursing we had 500 people come and see us at the last expo—school leavers and nurses who were going through the undergraduate program looking for places as a graduate nurse. That was a very good way of promoting our specialty, and we could probably do more of that sort of thing. Once you get the nurses into your hospitals, if you want to keep them you need to have good mentoring programs that are well funded and where

nurses are not required to have a full clinical patient load for a significant period. They need to have a period as a supernumerary nurse under direct supervision of an educator or an experienced nurse.

CHAIR—Which do you want: more clinical experience or more time for adequate education before they take on a clinical experience?

Ms Dawson—Education and support, so that, when they are one of the staffing numbers, they can take on a full patient load. It does take a period of time to grade up your skills—for whichever specialty you happen to be working in. You do not have a lot of contact with small, sick premature infants while you are doing your undergraduate course.

Ms Kent Biggs—One of the things we have to do—and I know that every nurse who still works has it in some way—is to help nurses regain their passion for nursing. We have a huge number of nurses who still work; they love what they do. Many nurses—and midwives maybe—have got on to the bandwagon of saying, 'We have a bad case at the moment,' and I think we do in some ways. Nursing needs to turn it around. We need to reharness the passion that first got us into nursing. That is why we are still here. Every nurse you see is probably passionate about what they do. I do not know how we harness that, but it is important.

One of the things that nurses do is bash each other up. We really should not, because we are fantastic people, we are highly educated and we are committed to what we do. There must be some way we can do that. I would like to find that way because, if we change the way we think, we can improve some of the ways of recruiting and retaining nurses.

CHAIR—'Bash each other up'?

Ms Kent Biggs—In the verbal sense. We are very quick to criticise each other. That has come out of not having enough staff to support what we are doing. We are working long hours. We are critical if we see somebody reading a journal article and feel they should be doing something else. We are very quick to do that.

CHAIR—Is this the 'horizontal violence'?

Ms Kent Biggs—Yes, more so the horizontal violence that has occurred.

CHAIR—You do understand that this title, this name 'horizontal violence', has been a great challenge to the committee. We are extremely interested to discover that it actually means bullying in the wards, for example. We had not thought about that.

Ms Kent Biggs—In some of the medical models as well they make the registrars work 80 hours a week because 'That is what we did'—what the consultants did—'so that is what we make our registrars do.' It is an ingrained mentality in health not to say, 'Well no, they should only work 38 hours a week.'

Ms Sims—Some of the other things are relevant education. Especially in emergency it is very practical and hands-on. You have to have a lot of background knowledge. People feel that sometimes their education through university was not totally relevant to this particular area. So

we need relevant education for that area and lots of support and time off for them—even just a few hours off for lectures within a working day. But at the moment everything is so busy that in-service education often goes by the board. So we need extra staffing if we can, or time to build in that old-fashioned in-service education, which is the kind of thing that renews people and props up their self-esteem—'I knew that after all' or 'I just need a bit of support in how to use this particular machine.' You go back with more self-confidence. Self-confidence generates that kind of passion, if you like. We need release for study in money and in time, again because everything has become so busy. The hospitals are often saying, 'We just do not have time to send anybody to this educational program.' That educational program might be the thing that keeps that person there. That is very important.

The other thing is career pathways. People need to be able to see, 'I can progress, I can be here, I can do some courses, I can be recognised for the extra work I have done.' At the moment a lot of people go off and do extra study, extra courses, and do not get any extra remuneration for that. They do not get very much recognition for that in the workplace. They see other people who have not done anything earning the same money and they think: why bother? That kind of recognition is important.

CHAIR—The TV programs about emergency nursing and so on have been described to us as a positive turn-off for people to come into nursing. Is there more understanding of it or are there at least some pluses at the margins?

Ms Sims—I think there are some pluses. I find emergency nursing very exciting, but some of them find that, as you say, there are a lot of older people there now. So, if you like, that excitement is not always there. There is a lot of the old routine work. So suddenly it is like: 'Well, where is all the excitement that I saw? I am just doing all sorts of ordinary things for older people.' I am not being rude, but if people come into emergency nursing for a buzz, then it is not always there any more. You are right.

Ms Brodie—With regard to attracting and retaining midwives, it is obvious that the image of the midwife is not necessarily a problem per se, so marketing the role of caring for women is not a problem. Notwithstanding the enormous potential of the three-year Bachelor of Midwifery, we do not see that as the only solution. The main strategies would probably be around recognition and utilisation of the role, particularly as I said earlier, and the role of the midwife within the public health setting. There is overwhelming evidence, not just of the benefits for the community and improving outcomes but also of cost effectiveness and satisfaction. Certainly the evidence based movement in health care demonstrates the potential of midwifery. All of this—the recognition and the promotion of midwifery—relates to the need for greater access to midwifery, and that is tied inherently to the funding of midwifery care. In spite of all of the potential benefits, women cannot access midwifery care readily. There is a barrier. They have to access a medical officer first, and the bulk of maternity care for healthy, well women is still provided by medical officers. This is inefficient and wasteful of the midwives we have.

Senator TCHEN—I will try to quickly run through a number of questions which ask you to clarify some of the points in the written submissions you have made. I will start with Ms Brodie, because her microphone is open. Horizontal violence is an issue which has been raised quite a number of times, as the chair indicated, and we have finally come to grips with what it

is. I am wondering whether it is part of the medical culture. Because it is such a hard job and you have to keep everyone on their toes, and this sort of pressure is on all the time, is horizontal violence part of the medical culture—medicine and nursing?

Ms Brodie—The term 'horizontal violence' comes out of literature around oppressed communities, from Paola Friere in particular. 'Horizontal' relates to the violence perpetrated on people in the same powerless position, so I think it happens within the levels of doctor. There is possibly some from doctors. There are other dynamics between doctors and nurses and between doctors and midwives. But, within nursing and midwifery, the violence is a symptom of the oppressed role and the lack of power that nurses and midwives perceive that they have. The root of it is not feeling powerful and competent and, in many cases, in feeling stressed, and so we lash out because we do not feel like we can control what is going on.

Senator TCHEN—Do you other ladies wish to comment on this? I understand that any kind of workplace violence, in the conventional wisdom, is not a good thing because it does not help work performance. But it seems to me that it is not only in the nursing area where, as Ms Brodie said, it is probably because of stress. It does not help the status but I noted that, from some of the comments you have made here and also from my other knowledge, the same thing seemed to happen in the medical profession. I wonder whether it is part and parcel of this need for everyone on the team to be vigilant all the time so that everyone is sort of picking on each other. Is that part of the culture and, if so, is it desirable to remove that?

Ms Sims—I think it probably is, to a certain degree. I have always felt that there was less direct horizontal violence in medicine with doctors. In fact, doctors will often stand up for their colleagues even when they know they are wrong. They will stand up and—

Senator TCHEN—Don't nurses do that?

Ms Sims—hide what went on, almost. Nurses never have. I am not saying you should hide people's mistakes, but I think you should also support people. I am not sure why, but nurses have always been very critical of their colleagues if somebody makes a mistake. I do not know whether it is too close to the bone, whether it is 'I could very easily do it myself', and somehow it is a defence—I am not sure. Certainly, nurses have always been very quick to criticise their colleagues for anything they might have done wrong—and, often, to criticise them in public, unfortunately. I find doctors often form a close band, don't they? They group together and support each other—

Senator TCHEN—And lawyers.

Ms Sims—whereas nurses will often very publicly pull each other down.

CHAIR—Doesn't the medical profession also enlist the nurses to keep it within the team?

Ms Sims—Partly, they do, but nurses seem to go against nurses, and I think that is quite sad in a way. I am not sure why it is, but it is certainly something that has been going on for a long time.

Senator TCHEN—That is interesting, isn't it? In every other field where this type of professional horizontal violence is almost built into the professional process—as it is in law and in the military—there is this so-called round the wagons business but, as you say, with nurses you seem to let it out into the public.

Ms Brodie—I think there is a strategy related to this which is around leadership. It is around developing the leaders and particularly the managers to take responsibility for the culture of the workplace. That probably requires extra training and resources, but it is about assisting all of us to feel more confident, competent and collegial, and that links to the culture that is developed. The managers of the units, unfortunately, have responsibility for that, as well as all the players.

Senator TCHEN—In December, in the midwifery area, you identified that a special type of horizontal violence which is damaging to the midwifery profession in terms of attracting new students is the horizontal violence, particularly with the practising midwives, against the midwifery students.

Ms Brodie—That is right.

Senator TCHEN—Can you suggest any way that we can overcome that? I am not sure whether it happens in other strands of nursing.

Ms Brodie—In the case of students, I think it is about bridging the gap between academic and practice settings. There are some good examples around the country, but there is still the need to bring the clinicians and the academics closer together so there is seamlessness and so that we all understand what the students are learning in the university and the pressures of the workplace. The report is that new students come in with a fairly inflated idea of what the work will be like and, unfortunately, they have to hit the ground running. If they do not, they get—

Senator TCHEN—So there was less of a problem when the nurses were hospital trained?

Ms Brodie—I think there were some great advantages, but certainly the move to the university sector is a positive step. There were some advantages in that we were all one big family.

Senator TCHEN—You talk about the difficulties of overseas qualified midwives in obtaining registration of practice in Australia. That seems to be fairly common in all professions. Is that a governmental issue or is it a professional issue?

Ms Brodie—Within the paper that I tabled on regulation, which was published in the *Australian Health Review* at the end of last year, we identified the problem. We have the Mutual Nurses Recognition Act, but we did an analysis of all of the acts in the country. With the exception of the New South Wales act, which has just been reviewed—there is a report currently available which recommends a change so that it becomes a nurses and midwives act to take account of the mutual recognition, particularly with New Zealand, and of the new midwives coming through the Bachelor of Midwifery. We will have the two registers. Currently, we have midwives of high standing in other countries who cannot get registered in Australia because the act is a barrier.

Senator TCHEN—Does the problem of overseas qualification recognition exist in other nursing areas?

Ms Dawson—No, because you have to be a registered nurse before you can come to the specialty. Midwifery is a little bit different.

Ms Onley—There are some schools of nursing where the qualifications are not recognised unless people go through a specific program set up for the registration of overseas qualified nurses in this country. Perhaps Professor Lumby or Ms Meppem, who are speaking later today, will be able to explain that in detail.

Senator TCHEN—Ms Brodie, you say that there are issues relating to the regulation of midwives in Australia that need special attention—could you say a bit more about that. Your answer might be fairly long so, if it involves quite a few minutes of explanation, could you perhaps give that to us in writing.

Ms Brodie—I wrote the paper I have tabled. It is published in the *Australian Health Review*. It is part of my doctoral work. I believe the issues are clearly identified in that publication.

Senator TCHEN—My apologies in that case. Also one of the issues you raised was about the options to make midwifery a more family friendly career: I take it you mean family friendly for the midwives, because one of your colleagues here talked about nurses needing to be more friendly toward families in the neonatal area.

Ms Brodie—Yes, I was talking about family friendly environments for midwives. I think we gave examples of more child care and facilities for midwives—and I know nurses do this as well—breastfeeding at the workplace.

Senator TCHEN—Chair, I have questions for each area. Should I continue?

CHAIR—You have one more question, Senator.

Senator TCHEN—Perhaps I should go on to aged care. I am sorry to miss you ladies in the middle; I have a lot of questions there too. Ms Onley, you said that you recommend that the scope and practice of enrolled nurses should be re-evaluated. For what purpose? Is that to define their task more, so that the work can be spread out a bit more to remove the load from registered nurses? In what areas do you think the roles should be changed for enrolled nurses?

Ms Onley—We have submitted quite extensively to the national review of nursing education on this point. In our sector, as in all other health care sectors, there is a legislative barrier in New South Wales to enrolled nurses fulfilling the extent of their role. We would very much support being able to employ many more enrolled nurses in our sector if we were able to give them more scope to work effectively to the extent of their education and practice. We would also like to see that we can further their education to further their scope of practice, but there is that legislative barrier to overcome. I cannot pre-empt anything that may come from the national review of nursing education, but I understand that a great deal of attention has been placed on this issue, and similarly with the nurses registration board in New South Wales. We acknowledge in our sector that enrolled nurses are extremely valuable. We would really enjoy

being able to employ more and more of them, not to relieve the pressure on registered nurses but to work more effectively with registered nurses and our other level of nurses that we have very commonly in our facilities—the assistants in nursing or the personal care attendants. For example, we see a much bigger role for nurses in low care hostels and low care environments in a supervisory and a clinical capacity. The biggest issue we face there is that legislative barrier to them administering medications up to and including set schedule 4 drugs, which they can do with appropriate education in the other states. I hope that has answered your question.

Senator TCHEN—Thank you. Why do you say nurse practitioner: is that a super nurse?

Ms Sims—Yes. I guess so. That is a nurse with advanced skills that you do not normally get. That nurse goes out and gets special training in advanced skills and a nurse practitioner almost would ultimately work independently. They will not replace a doctor but they are able to do a lot more than a normal registered nurse can do. They are allowed by law with certain training to do certain things so perhaps they prescribe some simple medications and treat a patient and refer them on appropriately. In some country towns they are setting up a nurse practitioners where they cannot get medical staff.

Senator TCHEN—Is a midwife a nurse practitioner?

Ms Brodie—No, the position of the college is that midwives are midwives, and there are various roles that midwives have, but basically a midwife is already a practitioner by law in her own right. In fact, through the NHMRC midwives can prescribe a limited range of substances and order a range of pathology tests as a routine. So we have not moved in that way.

Senator TCHEN—So a nurse practitioner is just a type of nurse who is able to set up for independent practice?

Ms Kent Biggs—In America and England there are neonatal nurse practitioners who work in neonatal intensive care and provide holistic expert care for babies. They supplement the medical. However, many units work primarily with neonatal nurse practitioners. New Zealand has just acquired their first registered neonatal nurse practitioner who happens to be a neonatal nurse. They work alongside the nurses within the unit and provide a continuity of care and undertake research. That is enhancing the ability for nurses to undertake research and be evidence based in their care.

Senator LEES—So that would be a step up in their career path?

Ms Kent Biggs—Absolutely. That would be something that neonatal nurses would like to look at in Australia because it works very well in the United States and the United Kingdom. One of the things that is happening in the registration of paediatricians is that the neonatal area is not compulsory. Often registrars will not come through a neonatal area because it is not a compulsory component. In the neonatal area, we work very collaboratively with our medical colleagues. Of all the areas in which I have worked in nursing, in general neonatal colleagues have a far more harmonious collaboration. Enhancing the nurses' education allows them to argue the point and put forward evidence based research.

Senator TCHEN—I still do not understand. I know there is no such thing as a plain, garden variety of clinical nurse. How does a clinical nurse become a practitioner?

Ms Kent Biggs—They have to go through extensive education. They would go through to masters level and then be supported by the medical consultants in their area to develop specific skills. It is an extension of nursing practice that allows them to do more than an experienced normal nurse would do. It is a career path.

Ms Sims—Miss Meppem would be ideal to answer that question this afternoon. She helped set up the nurse practitioner program in New South Wales and would be very clear with that, I suggest.

Ms Brodie—There is a nurse practitioner act and it is about advanced skills, autonomy and independent practice in the community.

Ms Onley—It is New South Wales legislation; 'nurse practitioner' is a New South Wales term.

Senator TCHEN—That serves to make me more confused.

CHAIR—One of the things that just about every witness has said to us is that, whatever the insufficiencies of the system at the moment, we are not going away from university education. For the *Hansard* record, all the people at the table have nodded in agreement, which means, as I understand it, that they are all strongly of the view that we do not leave university education. Could each of you briefly talk about two things that seem to me to be something we have to get a handle on. The push to get more clinical experience is being presented at the moment almost instead of university education or off-campus education. People are now saying to us, 'We need far more clinical work. We need nurses to have more experience on the ward.' We have learnt a whole lot of new words like 'getting preceptors to help up-skill people'—language that shocks me, but I am coping. Can you please explain to me a little bit about the seeming conflict and how best to manage it.

At the same time, can you tell me about another seeming contradiction, and that is that we all want to educate generalist nurses and we want people to have an experience in their undergraduate years of aged care or mental health nursing or paediatric nursing or whatever, but this seems to cut across the good core nurse and everything else, being in a postgraduate year. That seems to me to be another contradiction. Could you in 30 seconds each tell the committee how you see the education moving. All of you have said that it is so important. I think it has been fantastic that you have all said that one way in which we can help nurses have more job satisfaction is better education, but on-site, with preceptors, paid for by whom? Please explain.

Ms Onley—You mentioned the university and the quality of clinical experience as almost a dichotomy, as you see it, or as an anomalous situation. We maintain that a combination of the quality and quantity of clinical practicum experience is what matters while people are at university. We would seek to work in partnership with the tertiary sector to make their clinical practical experiences appropriate, relevant and worth while. Another thing that has been promoted within our sector's strategy is the possibility of a six- or 12-month—leaning more towards a six-month—post-registration year in which students choose a specialty that could

enrich their experience and build the experience they have gained at university into a solid basis for clinical practice in whichever setting we are talking about.

The third thing is the quality of education that can be provided within the work setting and also the support that can be given to nurses to extend their experience, their education, outside the work setting but then bring that experience back. That needs to be funded. In our case, we are funded very much by the federal government under the Aged Care Act, and that is where we would see the funding for that coming from. While not wishing to remove the fact that nurses must be accountable for their own self-development and education too, we would like to see partnership models.

Ms Dawson—I will go to the second part of your question first—about being a generalist nurse and a specialty nurse. I would not necessarily say that an undergraduate nurse needs to work in a neonatal intensive care unit in his or her three-year university program. Coming into our area as a postgraduate nurse in a new graduate rotation program would be much more appropriate, and you would not have to slot in 10 hours of neonatal care in a NIC unit as part of an undergraduate program.

CHAIR—Are you actually suggesting a clinical experience as part of a postgraduate year?

Ms Dawson—Yes. You cannot physically fit everything in a nurse's three-year education program at a university. Some things you just cannot do, so maybe some of the specialities can be done in their postgraduate year.

Ms Kent Biggs—There was a push to get clinical experience, and after having trained for three years we had the clinical experience but we did not necessarily have the theoretical. Obviously we have switched that around so that the nurses are now getting the generalist theoretical experience. There must be some time allowed for them to acquire the clinical experience without becoming 'the' registered nurse on 'the' ward who is in charge three months out. They do not have that clinical nous and experience. Perhaps they could have a lead-in time of 12 months—like the medical people who have a year of internship—where they do not take senior responsibility for units and are able to build up their experience.

Ms Sims—Yes, education is important for university courses. Certainly the postgraduates I have seen who are particularly good are those where some universities give them more hours of practical training within that university course. You need your basic education; that is very important. Even if the course were to be extended another year; there really needs to be a large core of practice built into their training. So, when they come out, it is not just a whole new world that they have never really experienced. I think it should be part of the university training.

The other thing that seems to work very well once they are out is for new graduates to rotate between three or four different speciality areas in that first year. In that first year, they should not be expected to take the full responsibility of a registered nurse. Perhaps they could be partnered sometimes by a more senior nurse. In those speciality areas, they could start with a more generalist area first—a surgical ward, a medical ward—and then work up to one of the more intensive speciality areas as they get to the end of that practical year.

Ms Brodie—There has always been a tension between balancing clinical and academic work. Clearly we know that nurses and midwives are not just a pair of hands or a handmaiden. I think the proponents of these shortened courses and less academic approaches probably would seek to have more nurses on hand to assist and follow orders rather than anything else. The academic work that is critical is actually teaching nurses to think, analyse and listen, to understand and debate the care and decisions. That is also important. In midwifery, we have a problem in getting the balance right—the quality and content of some of the courses and certainly the need to raise the standards of some of the clinical placements in midwifery is still an issue.

CHAIR—One area that has not been raised very much—more 'on the record' parts of the submissions—is the importance of recognising nursing as a university discipline. As I understand it from all the witnesses, there is absolutely no intention to retreat from that. Perhaps you are not the people to ask; I certainly want to ask the academic nurses. The evidence-based research is almost something that has taken its lead from nursing and it has application in other places. It seems to me there are two lots of research necessary. Some will be the research that the academics at the university will want to do that may not have an immediate relationship to the hands-on care. The evidence-based research would be a different sort. If I am wrong about that, please tell me. Could you just tell me about research in your area—if you know of it and if you drive it? Do nurses in the clinical institution have the opportunity to drive research and is that one of the things that some, or all of you, have said 'sexies up the workplace'? You have all said to me, 'Education seems to be a great way by which nurses feel better at work'. Perhaps they are more confident than anything else—but just a bit interested. Are any of you initiating research in your workplaces?

Ms Onley—Are you starting with aged care?

CHAIR—Of course.

Ms Onley—I mentioned development too. I made quite a point about staff development and I see from researchers that, in respect of education and staff development, the two go hand in hand and research is a big component. There is not a great deal of clinical research being done in aged care to my knowledge but it has commenced. It is very strongly encouraged by my particular organisation and by many of my colleagues who are outside my organisation. We are in the throes—ANHECA—of developing partnerships with two universities through which we can instigate, motivate and encourage research.

CHAIR—Which universities?

Ms Onley—Edith Cowan and the University of Newcastle, and we would welcome opportunities from other universities to do the same thing.

Ms Dawson—Neonatal nurses do quite a lot of research. The problem is if you are a busy clinical nurse and you want to do some research you often have to end up doing it in your own time and it is unfunded.

Ms Kent Biggs—With respect to neonatal nurses in New South Wales, the neonatal intensive care units have clinical nurse consultants who support the nurses to do research, so there is a fundamental push for research. I support what Jennifer says about lack of time.

Ms Sims—I would say it is often lack of time but I do think that nurses, particularly in emergency, are finding that if they put the time into research it will actually work to their advantage in that they can have practical figures they can use to back up their statements and get advantages for themselves. So in fact I think the interest is building.

Ms Brodie—I am involved in research into midwifery and maternity services models of care, and I see that process as a process of empowerment for midwives. It increases their education, and in the work we are doing we are overtly collaborating with doctors, and that improves relationships.

CHAIR—That has just saved me asking the next question which was about whether you do your own research or research in collaboration, but I will not run down the list. The last thing I wanted to ask you is: what capacity do you have or would you like or should you have to intrude into the nursing curriculum from your own specialty? When you see gaps, are you able to ring up the university and say, 'Now look here,' or do you have to go up a chain and around through the department or something of that sort? Can you influence directly?

Ms Onley—The short answer is yes.

CHAIR—And do you?

Ms Onley—Yes, through the curriculum advisory committees. I think they might vary from university to university, but in my experience they have a life of five years. I am very pleased to say that invariably for anything to do with nursing or recreation, leisure, diversional therapy et cetera there is representation from aged care.

CHAIR—Okay. Is that true for all of you?

Ms Sims—Yes. I have found that, certainly with emergency courses, the universities are very open to having input from clinically experienced people. In fact, liaising with a lot of universities is what we are working towards very much now at the college, and they are very happy to have practical input into their programs

CHAIR—A lot of people have suggested that they would like to but that it is no easy thing—that there is a health system over here and an education system over there and it is very hard to get the two to talk to each other formally.

Ms Brodie—I think there are some good models around the country, and there are some not so good models.

CHAIR—Can you tell us on the record which ones are good?

Ms Brodie—One that we know of in New South Wales which is working very well for midwifery is the partnership between the University of Technology in Sydney—and you will see Professor Jill White later—and St George Hospital, where we have a very strong interface with academic and clinical teaching in midwifery, and the research also. It is working well.

Senator LEES—Did they do the research which looked at the actual cost of midwifery and the difference in—

Ms Brodie—The research is collaborative. It is based at St George through one part of the university—the Centre for Family Health and Midwifery, directed by Professor Lesley Barclay, and the faculty of nursing, midwifery and health at the University of Technology is overtly engaging with the clinicians to do some of the teaching and course coordination and subject coordination.

CHAIR—Is that the question you wanted to ask, Senator Lees?

Senator LEES—No, it was not. Can I have one more question? I know we are eating into the time that we are supposed to have for morning tea, but I have just one last question. If students, before they went back to university each year—in other words, in February, when they seem to get underfoot, and again in December—were to go out in an observer role to, for example, aged care facilities or hospitals or with a midwife, would that be feasible? Would you have the capacity for that? At least at an observation level they would get more understanding as they went through their courses of what is going to happen to them at the end of the day.

Ms Dawson—As long as they did not need to be paid.

Ms Brodie—And as long as they got support.

Ms Sims—That is right, as long as there is support there. Then there would be no problem.

Senator LEES—So the nurses still have to do the support?

Ms Brodie—They have got to be looked after.

Ms Sims—Yes.

CHAIR—The story we have been told in many places is that, because of insufficient access to clinical experience, particularly since the university runs on a shorter year than the rest of us, there is the opportunity for people to work in the wards or to work in institutions in nursing positions during the so-called university holidays. This is something that has been happening in other parts. Mainly they are really working people, not students being supervised. They are also being paid a very modest emolument, which is very difficult because many of them find they can get more money doing anything else except being paid to work as nursing students.

Ms Dawson—Some of them use the university breaks to fund themselves for the rest of the year. If you put them on observer status, they might not be able to survive.

Ms Onley—You would also sorely deplete the aged care sector work force if you took them away from us and placed them elsewhere as observers.

Senator LEES—So you do have a lot doing that?

Ms Onley—We have very many undergraduate nursing students working in our sector. It is reflected in the peaks and troughs of the employment we have. But, to come back to your point about observation, I see that as very relevant. If it were for a short period, where we could build on the experiences we are giving them and if as observers they were supernumerary, I cannot see that the same level of on-site support from a university would be necessary for that brief period, as long as there were sufficient guidelines for the mentors who are actually working in the aged care setting they are observing. It is not like bringing students in to get clinical experience. Observing, to me, is something different.

CHAIR—I have a page of questions.

Ms Brodie—It depends on the clinical setting though, because observing in some places is more complex.

Ms Onley—I would agree with that.

CHAIR—We have to finish. I thank you very much indeed. It has been an extremely fruitful contribution. If questions occur to us—and there are plenty—would we be able to contact you? Likewise, if there is anything you would like from the committee, please contact us. If we want information, let me make it clear, we do not want a thesis. You are all very busy, and you have made your submissions. But sometimes we need dot points of information. For example, Ms Onley, if you have any information about the percentage of students who work in the aged care setting and what kind of wages or salaries they are getting, that would be very helpful for the committee—if you know it. If you do not, please just say, 'We don't know.' Thank you very much.

[10.34 a.m.]

BOLACK, Ms Sandra, Head Teacher, Nursing, Illawarra Institute, Shellharbour College of TAFE; and Program Co-ordinator, Enterprise and Career Education Foundation

CHILD, Miss Katherine, Student, Illawarra Institute, Shellharbour College of TAFE

ROOSENBURG, Mr Martin, Student, Illawarra Institute, Shellharbour College of TAFE

WATTS, Mr Peter, Business Development Manager, Enterprise and Career Education Foundation

CHAIR—We welcome representatives from the Enterprise and Career Education Foundation. The committee prefers all evidence to be taken in public. I cannot imagine that you want to tell us anything in camera, but if you should you could ask the committee and we would consider your request. The committee has before it your submission 866: do you wish to make any alterations to that submission?

Mr Watts—No.

CHAIR—I would like to ask you to make an opening statement, and I do very much appreciate that you have brought some real live practitioners from your organisation as witnesses. Welcome, students. Who will give us the opening statement?

Mr Watts—By way of a quick background to confirm ECEF's role, we are a federal government funded enterprise. We are at the vanguard of the movement that is pushing for change in the way that young people are prepared from primary school right through to the end of secondary school and beyond. We are principally an alliance broker. We recognise that education and the wider community need to come closer together in the development of young people—especially in terms of education and industry and business. We are a broker of those alliances.

Our principal area of activity and focus is local community capacity building, and we have examples today of one such project. But we are also using that information when we operate at a macro level to influence changes to policy and education where there is a strong push and a need to do so. Essentially what we are about is effective transitions for young people. We are operating at the front end of young people's development. Our new charter as an organisation is to actually work from year 5 through to the end of year 12, and the demographic is typically from about seven to 24 years of age. The role of ECEF is to increase young people's awareness of their choices in life and to help them to find multiple pathways for life after school so they can make successful transitions into the work force and into adulthood.

There were a number of key outcomes we were hoping to achieve from our industry activities—including the aged care project that we have undertaken for the last two years. One was to increase the level of awareness among young people of their career pathway options in the aged care industry. The other was to encourage or increase awareness of the industry's

opportunity to participate in this agenda, getting it actively involved and encouraging ownership at an industry level of the agenda. That is desirable from a sustainability point of view, as we are an initiator and a vessel through which this change happens, rather than the core part of it.

The aged care project was a two-year initiative. It was essentially about increasing young people's awareness of nursing—in its various forms—as an occupation, using the aged care industry as a pathway. However, it did not limit students' capacity to see beyond aged care and to look at other multiple pathways into nursing, if that was their choice. Equally, by gaining direct real life experience in these working environments, young people have also been able to make informed choices about whether or not nursing is the career pathway they want. We recognise that, if a young person chooses not to pursue that at the end of the day, that is an excellent outcome for them and an equally excellent outcome for employers.

I would like now to hand over to Sandra Bolack. We have initiated a couple of pilot projects in local communities, one in the Illawarra area in New South Wales and the other in Queensland. These pilots are rolling out now, in 2002, and Sandra Bolack, who is the head teacher in nursing at the Illawarra Institute of TAFE, is a critical partner in the Illawarra project.

Ms Bolack—Thank you, Peter. As Peter said, I am the head teacher of nursing at Shellharbour College of TAFE. We run what are called vocational education training programs. We run nursing programs for students who are still at school—in years 11 and 12. Last year, I was approached by ECEF to look at running a model of a program for year 11 students whereby at the end of year 12 they would have a nursing qualification. I looked at a model that would allow us to do that. I had a commitment to exposing these students to the reality of the culture of nursing and to what nursing really is, because I could see that, when students got to the end of their degree or whatever, we were losing them. So I talked to ECEF about a program whereby we could actually take the students on site into an aged care facility and deliver the whole course on site, so that the students had the opportunity to interact with the clients—the residents—and, at the end of 18 months, when they were halfway through their HSC, they would have their qualification, which would be a certificate III. Through ECEF, this has occurred.

The program runs in the following way. After a careful selection process—we went through a careful recruitment process—we selected 15 students. The students are all in year 11 at high schools across the Illawarra area. They came to us at the beginning of year 11 and they were educated totally on site at one of the Warrigal Care nursing homes—Warrigal Care has been a crucial partner in this as well. They came for a week at the end of the January school holidays, which was a great commitment on their behalf. They gave up the last week of their school holidays. They now attend for 5½ hours a week, on a Tuesday afternoon from 1 o'clock until 6.30, and they will do so until the middle of next year.

By the middle of next year they will have completed the course, which is a certificate III, community services (aged care work) nursing assistant. If successful, they will have that certificate level III qualification. That will give them the remaining period of time next year—the second half of their year 12—to concentrate on their year 12 studies, but the beauty of the program is that it contributes six units towards their HSC. So they will then complete their HSC with a nursing qualification which entitles them to go out and get a nursing home job.

Warrigal Care has participated very much in this process because they are having great difficulty recruiting people to their work force. Their benefit is a pool of potential workers. The student benefit is that they have a vocational qualification. If they choose to go on to do their undergraduate degree, they can work part-time with the qualification. It also establishes a great career pathway for nursing. From certificate III, they may progress into the enrolled nursing program with articulation and with advanced standing in some subjects. They may then choose to do a bridging program which will eliminate the first year of university. They can enrol in second year at university, with only second and third year to do at university. From this beginning in year 11, they can come out at the end with a degree in nursing as a registered nurse.

CHAIR—What is the difference between certificate II and certificate III?

Ms Bolack—Certificate II does not have a vocational outcome; certificate III does.

CHAIR—Can you explain what that means?

Ms Bolack—Certificate II is an introductory course into nursing: within the course there are no hands-on clinical skills. Certificate III provides a vocational outcome whereby you can get a job.

CHAIR—I am interested in how this runs, and I will ask both of you to tell us a little about it, if you do not mind. Ms Bolack, please help me get my head around it: they go to do the work mainly on site, but they are supported by whom?

Ms Bolack—The theoretical component of the course is delivered on site at Mount Warrigal Nursing Home.

CHAIR—By TAFE?

Ms Bolack—By a TAFE educator.

CHAIR—They can then take their certificate III and use that towards an enrolled nurse qualification at the same TAFE?

Ms Bolack—That is right.

CHAIR—Or at any other TAFE?

Ms Bolack—Yes.

CHAIR—At least in New South Wales?

Ms Bolack—Yes.

CHAIR—Then, if they are ticked off on an EN—which is a two-year course?

Ms Bolack—No. It is a 12-month program.

CHAIR—So after a 12-month program, they can then transfer and use that program as the first year towards an RN course?

Ms Bolack—The enrolled nurse program allows the student to apply to university. But we have also developed a bridging course from the end of the enrolled nurse program, which meets the deficit between the enrolled nurse program and first year at university. Enrolled nurses can complete that bridging program, which is 120 hours, and that entitles them to miss the whole first year of university. They can enrol in second year.

CHAIR—Where do they do the bridging program? At TAFE?

Ms Bolack—Yes.

CHAIR—How many of the ENs in New South Wales who want to transfer to RN courses can get a place?

Ms Bolack—I could not really comment on that. Chris Manwarring from TAFE will be appearing later, and she could probably answer that question for you.

CHAIR—The evidence we have received so far is that there are far more ENs wanting to do an RN course than are possibly able to get a place.

Ms Bolack—That could well be true.

CHAIR—I was wondering how many certificate IIIs would like to do an EN but cannot get a place.

Ms Bolack—I would suggest a very large number.

CHAIR—So there are more certificate III people who would like to go into nursing who are unable to get a place to do EN through TAFE?

Ms Bolack—I would suggest so.

CHAIR—That is something useful for us to follow up; thank you for that. Miss Child, tell us how you got into this.

Miss Child—I got into it just by getting interested in it and because my mum is a nurse as well, so I already knew what was involved. I also helped at the nursing home where she worked. It is a good job to get involved in.

CHAIR—Are you enjoying it so far?

Miss Child—Yes, I am.

CHAIR—You must be now doing that 5½ hours on Tuesday afternoon?

Miss Child—Yes.

CHAIR—From 1 p.m. to 6.30 p.m.—is that right?

Miss Child—Yes.

CHAIR—What do you do?

Miss Child—We learn about different things in aged care, and we watch videos on aged care.

CHAIR—Do you get to speak to the patients?

Miss Child—Yes, we do.

CHAIR—Do you get to touch them? Are you allowed to do hands-on care?

Miss Child—No, not yet.

CHAIR—You can hold their hands.

Miss Child—Yes, you can.

CHAIR—But you do not give them medication.

Miss Child—No.

CHAIR—Do you help bath them?

Miss Child—Not yet.

Ms Bolack—It only started this year.

CHAIR—I will not ask you what you were doing when you were helping Mother in the nursing home, Katherine. Does your mother work in a nursing home?

Miss Child—Yes, she does.

CHAIR—Fantastic. Mr Roosenburg, how did you get into this?

Mr Roosenburg—I first heard about it through my careers adviser at school. What interested me in the course was that I was able to finish my HSC and, at the end of my HSC, have a nursing degree behind me which would enable me to work in any aged care facility within Australia. That is about it.

CHAIR—Do you know what money you would get if you finished up working with certificate III to try and put yourself through university?

Mr Roosenburg—I realise it is about $32,000 a year.

CHAIR—That is full-time.

Mr Roosenburg—Yes, but I would imagine that would be considerably lower if I decided to go through uni and work at the same time.

CHAIR—We have been told that one of the problems is that people who have the opportunity to work in nursing homes get paid a relatively small amount as university students or TAFE students—and that has to compete with the fact that you can get more money managing Kentucky Fried or flogging slippers in Myers. Do you know this to be the case? I would imagine both of you know exactly how much you can earn. Is that right?

Mr Roosenburg—I am aware of what I can earn if I work full-time as an assistant in nursing. I reckon it is a reasonable rate, but there is room for improvement.

CHAIR—Elegantly said, Mr Roosenburg. Do the students have to pay to join this course?

Ms Bolack—No, the students do not have to pay at all.

CHAIR—Are you one of the first cabs off the rank in the nursing arena?

Ms Bolack—I believe this is the first time this model has been used. The beauty of the model is the interaction with the clients so, as this course goes on, the students will spend increasing amounts of time in the nursing home. At the moment we are having great difficulty keeping the clients away from the students and the students away from the clients because they are both loving that interaction.

CHAIR—It would be interesting to talk about that a bit more. Mr Watts, you talked about working with the industry. One of the big problems I have is knowing whether nursing is an industry or a profession. Since whenever, nursing has been a profession and university education is making it no less but possibly more of a profession. What is the meaning of the word 'industry' in your comments?

Mr Watts—That is a broad term to cover a range of sins but it includes both public and private employers and other stakeholders, such as nurses federations, unions and critical players, who can make or break this agenda. I should say, as a result of this two-year initiative, we have now broadened out into another new two-year initiative into nursing per se. So, while we have focused principally in the last two years on a narrow pathway through aged care, we now want to open that up to the various other pathways into nursing occupations. In that instance, we now have the chief nurses from a number of states participating, so obviously they do so at a bureaucratic or policy level as well.

CHAIR—I am interested in your saying that because it relates to my next question: to what extent have you discussed the content of your course, particularly as nursing is a profession now that is university educated, university based? Do you have to consider your curriculum with either the university nurses or the TAFE nursing course, or have you been free to develop something entirely of your own?

Ms Bolack—The curriculum is a standard TAFE course. It is a community services aged care work certificate level 3 nursing assistant, and so it is a mainstream course that we offer through TAFE. These students will do exactly the same as any other student who was doing that course throughout TAFE. It is just a different way of delivering the course. It is just a different delivery mode, but the content is exactly the same.

Senator LEES—I would like to ask either Miss Child or Mr Roosenburg: what do your friends think of this choice that you have made? Have you had any comments from your friends and fellow students?

Mr Roosenburg—My friends are very interested in the fact that I can actually walk straight into a job right after finishing my HSC or work during that second half of the HSC when I should be concentrating on it. They are considerably interested and they are thinking of taking up the course themselves next time it comes around.

Miss Child—My friends are very supportive and they are interested in that I can get a certificate while I am in years 11 and 12.

Senator LEES—What about your other studies? Are you both intending to matriculate? How does this, particularly with the time commitment you have made—obviously well after school hours on a Tuesday—impact on your studies for matriculation, if that is what you want to do?

Mr Roosenburg—It does impact a little bit on the Tuesday afternoon. If we had homework from the nursing course, then I would complete it that afternoon and not worry about it until the next Tuesday. But it has impacted on my preliminary year during year 11, because I have had to drop chemistry to enable me to do this course. Obviously that does not affect me getting UAI, or some other entry into uni.

Senator LEES—While you are off doing this course, other things are happening at school that you have got to keep up with?

Mr Roosenburg—No, I do not miss much at all. As I have said, I have dropped chemistry, and so I do not need to worry about that.

Miss Child—This course does not have much impact on my school work, because I always catch up the next day.

Senator LEES—I guess in a way it has perhaps helped your motivation to stay on at school.

Miss Child—Yes.

Senator LEES—I cannot ask you to comment for all 15 students, but do you feel it is helping their motivation to work and to study at school?

Miss Child—Yes.

Mr Roosenburg—Definitely, yes.

CHAIR—Can you get good marks, better marks, great glorious marks, for doing this course that will help your HSC final marks?

Mr Roosenburg—In what way do you mean?

CHAIR—I do not know how they judge things in New South Wales, but do you get assessed on this course?

Mr Roosenburg—Yes, of course.

CHAIR—And you can get a grading that means you could pass with 65, 75 or 85?

Ms Bolack—They will get a grading. This course does not contribute as yet to their UAI score: their tertiary entry level, the score required to gain entry to university. So this course contributes six units towards their HSC. Katherine has loaded units on top of that, so she will qualify for a UAI score, because she is considering going straight to university in a nursing undergraduate degree, whereas Martin is not aiming at a UAI score that includes this nursing program. We hope in the future that this course will be 'board endorsed'; it will then qualify towards their UAI score, which is very important.

CHAIR—'Board endorsed' meaning nursing board?

Mr Watts—Board of Studies. One of the critical issues is for the vocational education training that these school students undertake to have an equal footing, if you like, in recognition for the qualification, for their graduation from year 12.

CHAIR—Coping with the information in these inquiries is fantastic, coping with new courses is exciting and coping with how it is different from one state or territory to the next is even more eye-stretching. Perhaps not now, but would you be able to provide us with any information about how this compares to other states?

Mr Watts—Yes, we can.

CHAIR—Can you take that on notice?

Mr Watts—Yes.

CHAIR—Thank you very much, indeed. The points you are telling us about are really interesting. If you are talking about a seamless education, it is interesting to know what that means. Students do a course, and it is very nice, and they have a certificate; but it really does not give them much more than a bit of a pat on the head—that is, versus getting some kind of mark towards their next step. That is an area, you are telling us, that still needs further work?

Mr Watts—Certainly it is subject to the vagaries of the attitudes of each state and territory.

CHAIR—Who are you mainly arguing with: the state boards of education, or what?

Mr Watts—I would not necessarily say that we are arguing with them, but certainly we are trying to encourage—not just directly through our project but also through our various other stakeholders, including ANTA and the Industry Training Board, for instance—them to take up the issue to get that seamlessness across all states and territories. Certainly Tasmania and, I understand, South Australia are more advanced than the other states at this moment.

CHAIR—How are you funded through the Commonwealth? Are you funded with a bucket of money to do creative things with? For example, at the moment, if you got more money, could you produce more of these places for more students or do you only get funding after you have come up with the idea of a project?

Mr Watts—No. We have a four-year commitment from the Commonwealth, and our core funding is to support a range of what we call programs which, essentially, are local community based action groups that act as intermediaries between the education sectors. We take a cross-sectoral approach to that, so that there are Catholic schools, independent schools, public schools and actual employers within a given geographic area. They are effectively intermediaries between that supply side and the demand side. That is an area of core funding. We then have other funding to pursue specific initiatives, with an education focus but more with an industry led focus. As I said, I am responsible for the industry led initiatives. This is one of five different industry initiatives that we have running in this particular area, and they are all focused on industries that have recognised, enduring skill shortage problems.

CHAIR—If you have any further information about how the funding comes and how you redistribute it in your own institution or organisation, that also would be very helpful, thank you.

Mr Watts—Yes. Just to add to that: we are actually funded through the education department—our source of funding comes through the Commonwealth, federally.

CHAIR—In this project or in any of the projects, do you talk to parents?

Mr Watts—They are a fairly new constituency for us. We have focused for the last six years on developing these local partnerships, but we now have a new board with stronger recognition, and certainly direction from the government, to work at an even closer level on the ground, in terms of schools, students and parents—because obviously parents are an important influence in the career choices that young people make.

CHAIR—Are any parents able to do your courses?

Mr Watts—In the indigenous area, where we have a special focus, there is a very strong interest from parents in reconnecting with learning, because of their children's exposure to these opportunities.

CHAIR—Where is your particular population of indigenous people?

Mr Watts—We have 18 initiatives or projects running around the nation, and so it is the length and breadth of it. It is not in any one particular area.

CHAIR—Did you speak to the parents of Mr Roosenburg and Miss Child?

Ms Bolack—I did. It was a very careful selection process, because of many factors. The students had to get to the workplace from school. They also had to get home; in the wintertime it is obviously going to be dark. For any program to be successful, they are the variables that you have to eliminate or it will not work. I addressed all the careers advisers, went to the school meetings and so forth and made the program known. Then they sent me the names of prospective students and I interviewed each student with the parent to ensure that the student had access to and from the workplace, as I mentioned, and that the parent understood what the program was about. So the parents were very involved. As Katherine pointed out, her mother was a nurse. That was certainly one of the factors that came across: most of the students who were interested had a relative who had done nursing.

CHAIR—What do Mum and Dad do, Mr Roosenburg? Are they nurses?

Mr Roosenburg—No. My dad is an area manager at Sydney Water at the Illawarra, and mum is just a home engineer.

CHAIR—I was very interested to note that careful selection. Something that has been raised with us is that people go into nursing through the university: they just think it is a good idea and so they try it, or it is the only thing left, or they have put their name down for 3,000 other things. People have talked about the importance and the efficiencies, I suppose, of careful selection so that students can be helped very early in the piece to know whether they should or should not pursue nursing. Did you find that you rejected some people because they did not seem to be serious or was it mainly for external factors?

Ms Bolack—No, I did not reject anyone. The figure was 15, but I was allowed to take in extras to account for attrition. So we started off with 17 and we are now back to 14.

CHAIR—Why did they leave?

Ms Bolack—Unfortunately we had students from Illawarra Senior College, which is a school that takes students of all ages. We had a student aged 20, and personal problems became involved there. We had a deaf student who was coping beautifully with our program but not with her year 11 program. Another student we have just lost between schools—we are still trying to find that student.

CHAIR—I do not think I should pursue that. Have you had an opportunity to meet all the others in the gang?

Mr Roosenburg—Yes, of course.

CHAIR—Do you get up to mischief together? By that, I mean do you have the opportunity to socialise? Are you becoming a little group of students?

Miss Child—Yes.

CHAIR—What sort of things are you doing together, besides going to the nursing home?

Mr Roosenburg—That is practically it.

CHAIR—You do not drop off for a cup of coffee?

Mr Roosenburg—No; generally because everyone else lives so far away.

CHAIR—So you have to finish on the dot.

Mr Roosenburg—Yes.

CHAIR—Is that something you would like to do, Ms Bolack, to look at ways in which there is an opportunity for the students to become—

Ms Bolack—To cement the group. Yes, I would love to do that. But, quite honestly, there are 360 hours in the program and it is a lot of work.

Mr Watts—I would like to add that the focus also has been in terms of the responsibility or leadership of the TAFE or the education sector. The other important stakeholder in this is the employers. That includes their participation in the selection process so that they have an influence on the type of young person they are willing to take and wanting to attract to their place of employment. Equally, in terms of the common groupings formed, this is happening, we have noticed, both organically and systemically. Sometimes it is driven by employers who are particularly keen to foster a sense of identity amongst young people whom they have identified as talent whom they would like to employ in the future.

CHAIR—Because we have run so over time, I wonder whether my colleagues can cope with our finishing here?

Senator TCHEN—I would like to ask a couple of questions about ECEF, actually.

CHAIR—In two minutes, Senator Tchen?

Senator TCHEN—Yes. Mr Watts, you said you receive federal funding for ECEF?

Mr Watts—Yes.

Senator TCHEN—I take it that your main role is not so much to develop or build projects but to energise local communities so that they exercise their initiative.

Mr Watts—That is correct.

Senator TCHEN—This is not your only area, obviously; for the last six years you have been working in other areas. What sort of experience have you had in programs like this, encouraging young people?

Mr Watts—To put it in some sort of context, ECEP emerged as a new organisation in March last year. It had been the Australian Student Traineeship Foundation for the previous five years. It was set up to create a fire of enthusiasm within the community, right across the country, to take a level of ownership and action in relation to the development of young people. Whilst this predates my involvement with the organisation, I understand that we had some targets in our first four years to get some 2,000, 3,000 or 4,000 students involved and a couple of hundred employers. So the numbers were quite small. In relation to structured workplace learning, which has been the past focus of this organisation, there are now some 90,000 students and some 30,000 employers participating around the country. So, clearly, on what I crudely term the supply and demand side, there is a very keen interest and willingness to get involved.

Senator TCHEN—You have project in New South Wales and one in Queensland. Do the schools receive any monetary benefit from you?

Mr Watts—Obviously, we underwrite elements of the project cost, which includes the project manager, who unfortunately cannot be here today.

Senator TCHEN—Yes. You underwrite the costs, but the school does not actually benefit from it. Both Miss Child and Mr Roosenburg from Shellharbour TAFE are here. This is an aside—does Shellharbour TAFE have a gender specific uniform?

Ms Bolack—No. They wear a uniform but it is a nursing home uniform. You will note that Martin's badge has 'TAFE' and 'Warrigal Care' on it. That is so when the students are interacting with the residents they see them as part of their community, which is very important. The students wear a white shirt—similar to Martin's—dark trousers and comfortable shoes, as nurses always wear.

Senator TCHEN—Mr Roosenburg and Miss Child, what sort of reception do you get in your workplace from the staff and the residents?

Mr Roosenburg—I find that the staff and the residents or clients of the nursing home facility are very nice. We walk down the hall, we see each other and we say, 'Hi!' I have never heard a nurse knocking any other nurse because they have done something wrong, and I have never seen a nurse doing any harm towards a resident. In fact, I do not even think it happens at my nursing home. All the residents are very nice people. You just need to sit down with them to find out what they need. If they need something then you go and fix it or get it for them.

Miss Child—Yes. The residents are really nice and the nurses seem really nice to them, too.

Senator TCHEN—I am heartened to hear that because one of these days we will all finish up there.

CHAIR—We have to finish. We are sorry we kept you late. We thank you for being able to wait and provide us with very good information about something pretty innovative.

Proceedings suspended from 11.08 a.m. to 11.18 a.m.

DALY, Professor John, Head, School of Nursing, Family and Community Health, University of Western Sydney

McCALLUM, Professor John, Dean, College of Social and Health Sciences, University of Western Sydney

BROWN, Mr Alan, Senior Education Officer, Nursing, TAFE New South Wales

MANWARRING, Dr Chris, Manager Health and Aged Services, TAFE New South Wales

CAMERON-TRAUB, Professor Elizabeth, Dean, Faculty of Health Sciences, Australian Catholic University

RACE, Dr Paul Terence, Dean, Faculty of Nursing Health, Avondale College

WHITE, Professor Jill Fredryce, Dean, Faculty of Nursing, Midwifery and Health, University of Technology, Sydney

CHAIR—Welcome. The committee prefers to hear all evidence in public but if you wish to give any evidence in camera you may ask to do so and the committee would give consideration to your request. The committee has before it your submissions nos 784, 824, 812, 440 and 772. Do you wish to make any alterations to the submissions? As you do not, I thank you for coping with our being a little behind time and also for appearing on a panel today. We have been trying to get as many people as possible to have the opportunity to speak with the committee, and so we appreciate your cooperation in this panel type approach. I might ask you each to make an opening statement and then field questions. I will not emphasise that brevity is the soul of wit. Perhaps the University of Western Sydney could go first.

Prof. McCallum—I think most of this is clear in our submission. The University of Western Sydney has a substantial interest in nursing education. The University of Western Sydney is the third-largest undergraduate university in Australia and just under 10 per cent of our undergraduates are in nursing. We have approximately 1,500 nurses in training at any one time, operating across the north-west, central west and south-west of Sydney. The students who come into nursing are multi-ethnic and in that sense are an investment in the future of nursing in terms of its capacity to service multi-ethnic groups. The university also has a number of interests related to that. Some of these are pretty well covered in the Australian Vice-Chancellors Committee response to the inquiry, which we contributed to, and I will not rehearse those. I do not want to go into things now, but there are issues related to the costs of clinical education and the costs of value adding in nursing education that are specifically things I would like to talk about.

Prof. Daly—I do not think I need to add anything to what Professor McCallum has said, but I will just let you know that we have the largest school of nursing in Australia.

Prof. White—I want to put on the table some issues related to a major revamp of the University of Technology undergraduate program that does not appear substantially in our

submission but which has had an amazing kick-up. You can see that our headcount is starting to do a very nice smiley face for us and has led to a vast improvement in both recruitment and retention. At UTS we no longer consider that we have a recruitment problem in our bachelor's program. We also have multiple paths of entry for enrolled nurses or for people with other degrees to enter into nursing, and all of those are being successful.

Perhaps the two most important initiatives to put on the table are, first, the use of the clinical development units in third year, where almost all of the third year of our program is now spent in the clinical facilities, and the response from the area health service has been wonderful to that; and, secondly, the ability of our students to choose a submajor in their program so that they graduate as a generalist nurse but they have had the opportunity to do a submajor in medical-surgical, paediatric or mental health nursing. The mental health nurses are finding that this is really trying to substantially redress some of the issues that they had seen. In the postgraduate area there are some important issues to be dealt with in relation to the workplace difficulties that preclude students who even want to step forward for postgraduate education moving out of their clinical environments to do so. I am very happy to address that further.

In relation to research, we have significant issues about research funding and nursing research funding, funding of the clinical professorial units and clinical professors, who I believe are leading the way in real workplace focused research so that we link the notion of practice that is embedded in research and research that is embedded in issues of practice. I think there are issues to do with partnerships that some of the research projects are now starting to address and I would like to put on the table to mention the AUTC project. The Australian Universities Teaching Committee of DETYA have just got the final report on an evaluation of curricula across the country, and I was involved in that. Part 2 of that is looking at best partnerships for best clinical learning.

I would like to also put on the table that I would be most happy to speak to issues related to midwifery—given that we were the first institution to change our name, to resurrect the title 'midwifery', which nearly five years ago I perceived, when I came back to this country, to be almost dead—and what we have done to move forward with what we see now as one of the most successful midwifery programs in the country.

Prof. Cameron-Traub—Australian Catholic University has three faculties of which one is the Faculty of Health Sciences. The Faculty of Health Sciences has five schools of which three are nursing schools. There is a school of nursing in Queensland, one in New South Wales and one in Victoria. I believe you have already seen a submission from the school in Victoria. In New South Wales—the dean is located in New South Wales—effectively we have to work across the eastern seaboard with regard to the nursing courses, and all activities, quite clearly, have state implications as well as the national approach. The Bachelor of Nursing course is run in each area. It is offered in Brisbane, in Sydney—through North Sydney—and it is also offered through Melbourne and Ballarat. So we have representation in four cities. The issues that have been raised in the submission from the three schools of nursing are fairly common across all states, although some may be highlighted more in one state or region than in another. I am sure that the committee will be able to differentiate the information, but I would be happy to address any questions if needed.

Dr Race—Avondale College is somewhat unique. We are a private higher education institution. We receive no government funding for our nursing program. The nursing program operates on two campuses. There is a Cooranbong campus where the students do six months or the first semester of the program, during which they sit in with other students on some of the foundation subjects such as science, social sciences, et cetera. They then move to the Wahroonga campus, which is co-located with the Sydney Adventist Hospital, and complete the remaining 2½ years of their program. The students enter the program from anywhere in Australia and come from any background. We predominantly take students from New South Wales—perhaps 50 per cent of our student entry—but the remainder are from various states of Australia and there are a couple from New Zealand. We are only a small program; we have around 120 undergraduate students at any one time and an intake of about 40 once per year. Perhaps our claim to fame, if you could call it that, is that we have a unique program that integrates a lot of clinical practice in the Sydney Adventist Hospital's acute care areas. Also, outside the program, there is a work component, which is unrelated to the educational component, where the hospital itself utilises the students as assistants in nursing. Given the current circumstances in hospitals I could come back to make comments about how easy that is to work—because I understand that is one proposal that has been suggested by some. I would be happy to comment on how easily that is facilitated these days.

Dr Manwarring—Thank you for the opportunity to be here today. TAFE New South Wales is part of the vocational education training sector. It provides education up to and including the Australian Qualifications Framework at an advanced certificate level. I elaborate by saying that this submission focuses on enrolled nurse education and training, not undergraduate training. Our written submission included reference, also, to a Diploma in Nursing for enrolled nurse. We would like to advise the inquiry that the National Review of Nursing Education and the Australian Nursing Council Inc. enrolled nurse competency project may conclude that enrolled nurse education qualification should be at either certificate IV or diploma level.

In New South Wales we have a very clear pathway for the education of nurses, commencing at a certificate II level, which is an access to nursing which has no vocational outcome. We also offer a certificate III, assistant in nursing, which was alluded to by previous speakers, and we train over 4,000 assistants in nursing per year. We have a certificate IV in enrolled nursing, which is part of the contract with the New South Wales Department of Health. It is offered at 11 TAFE colleges statewide and we provide education and training for 700 enrolled nurses per year.

We also offer post-enrolment courses for enrolled nurses to work in specialty areas and we also offer bridging courses into undergraduate programs. This provides students with a three-week educational program that we deliver in partnership with university sectors. Students are then able to move into the second year of the undergraduate program. With the bridging course, our numbers per year will range between 140 and 180 students. We also provide a pathway into other areas such as mental health, aged care, developmental disability, parentcraft nursing, perioperative nursing and rehabilitation.

In TAFE, as I have just mentioned, there is a clear pathway for nurses from certificate III to undergraduate level. TAFE New South Wales recommends that the inquiry consider endorsing that education and training of enrolled nursing does remain within the VET sector. The other issue that I would like to raise at this point, which was not within our submission, is that TAFE

New South Wales is also developing a course as a traineeship for enrolled nursing pending IR issues with award structures. This may be alluded to this afternoon by the nurses association.

The other part of my submission is that, as you can see, we already have a bridging program that moves into the undergraduate program. Our submission has highlighted that the enrolled nurse education program needs to be embedded into the first year of the undergraduate nursing program and provide exit points—as we currently do—either exiting as an enrolled nurse or moving into the second year of the program. That is all at this point. Thank you.

Senator LEES—This will be, I guess—depending on whether you are from TAFE or the universities—taken in different ways, but I am particularly interested in selection of students. I note from the submissions that you are in some cases not necessarily taking students straight from school but are looking at a raft of other processes of recommending students who believe they are genuinely interested in working through. So if I could begin by asking—and this is probably just the universities—about the level of score for those coming out of school. I know this differs from state to state, so I guess roughly it will be a percentage mark that students need to get. Also in your answer could you detail other ways of finding students. As we know, about 60 per cent of those going into medical courses this year were not direct from school. I am particularly interested in how many students you are getting from which area, how many are referred directly from school and how many turn up aged 30, referred from the local health service. Perhaps we could start with the universities and then move to TAFE.

Prof. McCallum—Would you like me to start?

Senator LEES—Yes; it is covered in your submission to some extent. We are particularly looking at the entry score. We have heard various stories about where that is going in different states.

Prof. McCallum—The entry level for all UWS courses is a UAI score, a University Admissions Index score, of 60. Under the structure of the University Admissions Index, 60 is about the median score for the graduating class in year 12. So it is above 50 per cent. All our students come in with that level, with the exception that we have two special entry schemes. To do these schemes a student has to live in the catchment areas of the campuses of the University of Western Sydney. We call it a regional entry test. Students entering that way into the university complete a STAT test—which is the test of the Australian Council of Educational Research, which is a test of their ability to take on university work—and they have to score a norm in that STAT test higher than 60. They have to get a UAI score within 10 points of the 60.

We are providing an alternative mode of entry for people who in all alternative tests, we believe, are properly prepared for it. This test is a very important part of the equity program of the University of Western Sydney. In Western Sydney there are a lot of high schools that do not perform well. Getting anybody above the level of 60 is quite exceptional in some of the high schools of Western Sydney. That being said, we take approximately 40 per cent of our students through that mode of entry. It is well controlled and quite specific about how we do it.

Prof. White—At UTS this year our UAI cut-off was 73.4, which was the highest in the state, but we do have equity programs that allow us to have students make a case for bonus points. We do not go below 60. There have been very few of those this year. Included in those will be the

Aboriginal and Torres Strait Islander student entrants. We would like some more HECS places from the government because the program is proving to be very strong. We have 343 new students this year of a total of 819, so it is strongly increasing. We have multiple entry programs, possibilities into the Bachelor of Nursing program. ENs can come in with a certificate 4, and we will take all the ENs we can get. They are fantastic and they work very well through that program. It is a special program designed to the same exit point as the other, but to meet the needs of enrolled nurses. We have 91 ENs this year and 151 in the program all-up. We do encourage students who already have a degree in other areas to come into the nursing program. They can graduate in two calendar years if they do that.

CHAIR—Professor White, could you provide us with a copy of your graph that shows a kick-up in retention and enthusiasm for nursing?

Senator LEES—And details on the new program you mentioned in your introductory statement.

Prof. White—Absolutely.

Prof. Cameron-Traub—In Queensland the School of Nursing takes in students fairly consistently with an extremely high—for nursing—ENTER score. It has had very strong demand. Consequently the university entry for year 12 is held at a significant level and has the potential to increase further, simply because of the demand. We also take in from New South Wales. We are very pleased to inform this inquiry that our numbers in New South Wales have significant increased in the last 12 months. We used to take about 110 students. This year we have had places for 145 and we have been able to fill those places comfortably. The UAI score is increasing and is certainly comparable to what it should be relative to the other states.

CHAIR—What is it?

Prof. Cameron-Traub—It is 60-something—I am not sure. I do not, unfortunately, have at my fingertips the UAI, the ENTER score, et cetera, across all my schools.

Senator LEES—It differs from state to state. We are finding it interesting.

Prof. Cameron-Traub—I can certainly find out and provide you with the actual cut-offs for each of them if you wish. In Victoria the ENTER score was this last year the highest for the Melbourne universities. As I indicated earlier, we have an intake into St Patrick's campus located in Fitzroy and also an intake into the Ballarat campus. They are two separate intakes. The regional intake into the Ballarat campus is about 50 students and has been at a similar level for many years. Its entry score has also increased. At St Patrick's campus—Victorian numbers are not the same as Queensland or New South Wales numbers—it was one of the highest for all courses at ACU and also the highest of the city universities for entry into nursing.

In addition to all of those year 12 entries, we have a number of programs across all the schools to enable enrolled nurses to come in with recognition of prior learning. In New South Wales in particular we have had a very large intake this year of international students into the Bachelor of Nursing program. These are people who are already resident in Australia who have increased our non-HECS numbers by international intakes. In New South Wales we have had a

university preparation program operating quite successfully and we are going to extend it to the other states as required and as the opportunity becomes available to us. The university preparation program prepares the people who did not have a satisfactory UAI score to undertake some preparation and studies to enable them to come in at a later date.

Senator LEES—Do they sit something similar to what you require in terms of that separate examination? Is that also used by the Catholic universities?

Prof. Cameron-Traub—I do not believe so. We do have a number of processes whereby we select students and they differ somewhat between each of the states.

Senator LEES—We will look at TAFE and then come back to the middle.

Dr Manwarring—I will hand over to Alan Brown at this point because he is involved in all selections of enrolled nurses throughout New South Wales.

Mr Brown—In the assistant in nursing course, per year we would typically train about 4,000 students and in the enrolled nurse course, we would typically train approximately 700 students per year, with the potential to grow that if need be. The selection of the enrolled nurses is essentially a responsibility of the Department of Health, through the area health services. The enrolled nurse program to date has been a contract that TAFE has enjoyed from Health for the training of enrolled nurses.

Senator LEES—So the places basically have to be out there and then you do the practical?

Mr Brown—We provide the theoretical. The clinical environment is an area health responsibility. The selection of the students is then their responsibility as these students are employees during that 12-month period. We would like to point out that we have a retention rate of over 95 per cent for the last 17 years of enrolled nurse students through our program.

Senator LEES—On the certificate courses: do nursing homes in New South Wales have to employ someone with a certificate or, as happens in at least one other state, can they basically employ someone off the street?

Mr Brown—There is certainly an increased need and there is an expectation that all of their carers would have a certificate III level, but there was a period of grace—I am not sure when that expires—where their workers needed to be upskilled to the certificate III level.

Dr Manwarring—I can elaborate on that. In 1996, with the assistant in nursing review, it was suggested that all assistants in nursing, by the year 2000, have a qualification at an Australian Qualification Framework of a certificate III minimum.

Dr Race—Avondale College has a UAI of 65 for entry to all courses and an equivalent from other states. We undertake an interview with students who do not fall within that range. If they can demonstrate that there is some factor that has impacted on their UAI result, we will still take them into the program. If they can demonstrate in the first semester their capacity to complete the studies, then they continue. We are not part of the Universities Admissions Centre, so all students applying to Avondale have to do so directly to the institution. We find that they often

apply through the Universities Admissions Centre to a university and also apply to us. So there is some difficulty in determining student numbers right up until registration day for us. Until they get their offers from other institutions, they may choose a fee-paying course such as ours or a HECS-funded university course. We also have a process whereby we can request that students undertake a special tertiary admissions test, something like a mature age exam but for a younger age group, where they can demonstrate their capacity to deal with the study.

CHAIR—How much do you pay to be a first-year nurse?

Dr Race—Student fees are around $8,000 per year for tuition and facility fees.

Prof. Daly—I would like to make a couple of points. At UWS, the minimum score for entry to nursing this year was 60 and we filled our quota comfortably. We have no vacancies. It is also important to note that we get some very bright students in nursing. One student who came to us late in the day after we had filled quota had done a year of teaching at another university and had a UAI score of 93. It is very important that people are aware that not all students come in with a score of 60. We have some very bright students.

CHAIR—That is terribly important. When I did the teaching inquiry a few years ago, we had exactly the same kind of concern. People kept telling us what was the low score to get in but failed to point out that, particularly after advertising and promoting teaching in Queensland, there were a very significant number of high score entrants choosing to go into teaching. So that is welcome. In the future, we will have to ask for top and bottom scores.

Senator LEES—It has been quite disappointing to see in my local papers that, for some of the students who got very high scores who wanted to go nursing and teaching, the expectations of parents, friends and even of media were, 'They'll almost certainly switch over automatically to medicine,' and it is not what they want to do.

Prof. White—I would like to add something to what has been said in relation to making sense of the New South Wales UAI of 60. If one can stretch one's mind back to old hospital days—and I usually choose not to do that—major hospitals had a cut-off at that stage which used to be equivalent to an old 250—that is, exactly the same as a 60. So I think the apocryphal stuff of, 'She's a good girl and she would've made a fabulous nurse if they still had hospitals' is not true. They did not take everybody warm and upright into hospital programs. In fact, the cut-off that we are using is about the same cut-off that the hospitals used to use. In relation to the numbers of top students, this year, for example, just in our cohort, we have 23 students with a UAI of over 85.

CHAIR—Given that you do not ever think back there, but if you inadvertently did, would you be able to give us any data on the drop-out rate back then? One of the things that has been told to us has been that there are now higher drop-out rates since they are at universities. Any number of people would say that simply ignores the fact that there was a very high drop-out rate through the hospital.

Prof. White—I can speak for Royal Prince Alfred Hospital. There was greater than a third drop-out through the program. What people also forget is that there was a very large attrition

rate on graduation. So there was an attrition rate during the course, and there was an enormous attrition rate on graduation.

CHAIR—Like what?

Prof. White—There were all sorts of things: wanting to be married, wanting to go overseas, all sorts of other things. People often saw their nursing training in those days as finishing at graduation rather than beginning. Now we have students who see their career beginning when they graduate. We have a two per cent drop-out rate from last year to this year in the UTS program.

Senator LEES—That was my next question—to look at drop-out rates. This issue has been raised with the committee. Building on what Senator Crowley was just asking, in terms of drop-out rates, I know one university in South Australia has done a little bit of work across all faculties looking at what it is. I am more than happy if you want to take this on notice. You have already partly answered my question. Can you compare students who come straight from school with the ones who are more mature? These more mature students might have done a special entry test. Or you might have supported them and decided that they were suitable for university or TAFE—rather than having them come to you and saying, 'My entry score is so and so.' Is there any difference?

I notice with interest that the submission from the University of Western Sydney relates to the ethnicity mix of students, which is fascinating. Around 50 language groups are catered for at university. Is there any factor there that we can point to and say, 'Here's one ethnic group for whom nursing is posing real difficulties,' or do we go back into the school system and look at public versus private students? Have you done any work on drop-out and the factors that cause it? Perhaps we will start at the other end with TAFEs this time. You have a very high retention rate, but do you see any issues?

Dr Manwarring—The three or four per cent which we have identified—and we do a longitudinal evaluation study of our students—have left for family reasons or they have not been able to meet the requirements of the block 1 exam where they have to do a category A, which is a fairly large, extensive exam, or they find that nursing is not what they wanted to do. I think there is a high retention rate because of the amount of work that goes into the selection process and the support that happens at the very beginning through TAFE, and there is a very strong collaboration and partnership we have with the area health services. There is that mentorship and support. Our retention rates are based on that. The students who leave the system are usually those with family problems, those who have not met the exams or those who do not want to do nursing.

Senator LEES—On to the college system—

Dr Race—Our retention rate is somewhat distorted by the fee paying situation. We do always lose a number of students at the end of first year, once the impact of the fees hits them hardest. They have met their first year's fees, perhaps with their savings. Then when they are faced with paying fees for the beginning of the second year, they seek to transfer to another institution. That distorts our drop-out rates. We find that the students who we make special provision for entry are probably our least problematic students, those who are least likely to drop out. They

tend to be the ones that are more committed to coming in and completing the course. Of the other students that do drop out, it is often for personal reasons or because they do not like nursing. It is at the end of the first year, after they experience the significant clinical practice that they get in their second semester, that is make or break and they decide whether they want to stick with nursing.

Senator LEES—What about Catholic universities?

Prof. Cameron-Traub—Our attrition rate is very small pretty much across all three schools. It always impacts around the HECS date so that we have to estimate how many offers to make and how many enrolments to get in order to anticipate what will still be left at 31 March, and similarly when the HECS numbers are done. From a statistical point of view, it is difficult to say that that is the drop out because it depends on how many are actually in the system at the HECS census date. If we were to look at the enrolments, at the number of offers and the numbers who walk in the door on day one of semester one and compare it with the number at the HECS date, we would probably find a greater attrition in that first period of time. Unfortunately the statistics do not really help us to work that out. That applies to all courses. It is certainly not unique to the nursing course.

In terms of Professor White recalling the attrition rate in the old hospital system, I had experience at a hospital other than one in Sydney. It was my understanding that we had anything from a 30 to 60 per cent, or possibly higher, attrition rate. I can recall my own graduands from first year right through. About 60 to 70 per cent of us did not complete the course, so the figure was very high. One of the reasons the attrition rate in university courses may well be less is that we are able to give them strong support as students in the university system, rather than confusing their lives and making their lives much more complicated by having to provide a service at the same time as being students.

CHAIR—Do students at the Catholic university have to pay up-front fees for their nurse education?

Prof. Cameron-Traub—Not HECS students.

CHAIR—So you have HECS students as well?

Prof. Cameron-Traub—We have HECS students. We also take in fee paying students.

CHAIR—How much is the course for a fee payer?

Prof. Cameron-Traub—I think it is $850 per unit.

CHAIR—Multiplied by how many units?

Prof. Cameron-Traub—Four. It is very expensive.

CHAIR—I hope you are not listening to that, Mr Race. Your students are going to say, 'Why are we paying twice as much?'

Dr Race—We have a facility fee and an education fee, so it depends on which figure is quoted.

Prof. Cameron-Traub—We have a facility fee, or a student service charge, which is a very small amount.

CHAIR—Why on earth would I want to pay $8,000 when I can go down the road to get a comparable—I think that is a fair way of describing it—education for no money up front?

Dr Race—I would argue that it is perhaps not comparable. Our program is smaller than the university's. We have greater support for students because of that. Because of our clinical links with the Sydney Adventist Hospital, our students get what we believe is a stronger clinical basis to their practice. To assist in offsetting the fees, the hospital does engage the students in some assistance in nursing work outside of their academic program. The students are employees of the hospital and work in the hospital as assistants in nursing.

CHAIR—From year 1?

Dr Race—From the end of year 1; after they complete their clinical practice in year 1.

CHAIR—So they could effectively work over the holidays, for example?

Dr Race—Yes.

CHAIR—At what pay rate?

Dr Race—I think the base rate is somewhere around $11 an hour, plus penalty rates. There is an award rate that they are paid.

CHAIR—They would have to work a for long time to get their $8,000 worth, wouldn't they, Dr Race?

Dr Race—They would.

Prof. White—One of the things that we found as we did evaluations of our program was that the mature-age students were predominantly leaving for financial reasons. One of the things that we have done to try to counteract that is to construct their timetable so that it allows them time to work. Almost all of our students have to work as well. Gone are the luxurious days of being at university just as a student. The students always have no more than three days in the five-day week where we require their attendance at university, taking notice of the fact that they have to earn a living. Many of those students work as AINs. In fact, at the moment we are in consultation with the Nurses Registration Board and the state government to see if it is possible that our students, after 18 months in their program, can enrol as enrolled nurses. We believe they more than meet the competencies. They would then be available to work as enrolled nurses for the winter bed strategy. They would not be used just as the cheap labour that I believe student nurses are used as at the moment. The whole way through their program, to a day away from being a registered nurse, they can get employment within our state hospitals only as AINs.

There is one further comment I would like to make, and that is in relation to Aboriginal and Torres Strait Islander students. We have employed a lecturer who is an Aboriginal woman, and we have found that people know about that now. There was an 18-month investment in that project and we now have people stepping forward from areas well out of Sydney because they feel that, with Angela there, they will be safe. That is what they have said. The figures are still only small, but from a high attrition rate and very small numbers we now have 10 who are stable. That is a really big improvement for us, particularly given that we are in the northern suburbs of Sydney and that that is not necessarily seen as the typical place that students would be attracted to.

Prof. Daly—At UWS I would say that the attrition is low. I cannot give you a figure this morning, but I am happy to provide you with that information on notice if that would be helpful. We retain the vast majority of our students. We have a significant number of exceptional pattern students. Those students take longer than the three years to complete the course, usually because of failure in a subject, misadventure, difficult personal circumstances or socioeconomic factors. We put a lot of additional resources into providing support and remediation for our students in the areas of English language skills and maths. But we set a standard and if the students do not reach that standard, they do not get through the subjects. Exceptional pattern students are probably a bigger issue for us than maybe for some other providers.

CHAIR—What in your past education, preparation and training equipped you to realise that you have to do all this with your students?

Prof. Daly—It is something that has come with our experience and it is something that seems to me to be peculiar to UWS. I have taught in several schools of nursing—in New South Wales, at Newcastle, at UTS, at Charles Sturt, at UWS—and it probably goes back to problems with the standards, and the students from the high schools in much of our catchment area are not well prepared.

CHAIR—I hate to be misunderstood. It is very interesting listening to the different institutions and hearing how you are trying to arrive at the same end product, effectively—forgive me using such a vile, non-human word—but the ways each of you have to do this are singularly different. You are actually responding in a way that in times past I think institutions did not, which is by recognising different needs of students. I am wondering where in your background you got educated to know how to pick up on what students need?

Prof. Daly—I have been a nurse educator for a very long time and I have been a nurse for 20 years. I grew up in an impoverished area of the state and made my own way through my own educational experiences. A lot of my colleagues are probably not dissimilar. You just develop the knowledge.

CHAIR—Are you telling me that, essentially, there is nous in universities for nurses?

Prof. Daly—I would say that if you look at nursing—you have me on a roll now—some of the very best and most outstanding educators and teachers in universities currently are nurses, because we have gone through the teacher training programs and many other academics do not do that.

CHAIR—Teacher training programs provided by whom?

Prof. Daly—In the old hospital system, if you went into teaching, you were provided with courses in clinical instruction and principles of education. Many of us have done postgraduate diplomas in education. Then there is specific teacher training. I have an undergraduate degree and a master's degree in education. The thing that you used to do if you were a hospital nurse educator, to have credibility and consolidate your position, was to go and get training as a teacher.

CHAIR—I am extremely pleased I asked. Maybe this is something that has not been stressed enough, but I am very pleased to learn that. There are numbers of other disciplines in universities where in other inquiries we have learnt how little training they do in teaching. They may write good research papers, but they may be very insufficient in teaching. That is a very useful addition to my understanding in particular. Thank you.

Prof. Daly—The other thing I can tell you is that we are often praised in the tertiary sector for our skills in curriculum development. We stand out from the rank and file of other disciplines in our ability to develop high quality curricula. We are very much into rigorous and ongoing evaluation of learning outcomes.

CHAIR—And no universities now would dream of saying, 'We should not be having nursing in our institution, it is just an applied science'?

Prof. Daly—I think the attitudes have changed a lot since we went in in 1985, and now nurses are doing extraordinary things like becoming pro vice chancellors and deputy vice chancellors, and we are still quite a young discipline.

CHAIR—It is all right. I did medicine, and many years ago they were telling me that it did not belong, only philosophy did.

Senator TCHEN—May I first comment, regarding the universities and the schools of nursing, that it is very good that you do not seem to be in the field to compete with each other but to work with each other. Senator Lees has asked a number of questions regarding attrition rates and entry levels and those sorts of thing. Putting the question in a different way, have you noticed any imbalance between the demand for nursing education places and the supply of nursing education places? In other words, are there many more people applying for places at universities and other schools of nursing than you have places for?

Prof. Daly—Certainly at UWS we are constrained. Our intake target this year was about 435. Our UAI cut-off was about 60, so to get more students we would have had to look at dropping the UAI, which we did not really want to do. But I think there are untapped sources and we are constrained at the moment. For example, we are very interested in running with a two-year master's preparation for entry to nursing program that would probably appeal to graduates of other disciplines. I think that there are quite a number of people out there—arts graduates, science graduates—that would be attracted into such a course. That is a group where we probably could recruit a lot more. If we were allowed to trial other models—for example, sandwich courses—we could certainly bring more people in. We all have some really good ideas about how we can increase demand without necessarily diminishing quality, but we are very frustrated

in our efforts to find people to listen to us and to give us opportunities to try those new approaches.

Prof. White—Certainly, we have not meet our targets at UTS in the last few years but we have now been able to do that, and just at the time where we are able to do it we have met with DEST's desperate clamping down on overenrolments across universities. Certainly at the moment we are in a situation where, if nursing were able to have additional HECS places and they were quarantined, that would be the ideal circumstance. Then we could cut out any of the argie-bargie that has to go on at university level. In our institution, we are fortunate that our vice chancellor and our deputy vice chancellor have been very public in their support for nursing and they allow us to take the number of students that we can. That does not stop us having fights with other deans who feel that they have been cut back because nursing is being treated generously. It is a real issue that needs to be looked at at the federal level. I am aware that New South Wales has had more of a problem in the last few years than many other states but, when you look at the number of tertiary institutions we have compared to the other states, I think you see that that is part of the issue.

Dr Race—We certainly have scope to increase our enrolments but again the funding issue is the barrier for us. There are fewer students who are willing to pay the amount of fees we have discussed for a nursing degree. We certainly could increase our enrolments if there were funding of our program. At present, the funding is entirely provided by the students themselves, with some supplemental funding from the Sydney Adventist Hospital.

Senator TCHEN—Can I come back to a point you made, Dr Race, in your written submission. On your first page you said that the proposal to remove HECS fees for nursing is a significant concern to you. Why is that? You are not involved in HECS.

Dr Race—Yes, but if there were a competitive advantage, if students going to another university program did not have to pay any HECS fees, then the disparity between our costs and the costs at another institution would be significant.

Senator TCHEN—I see. So when you were talking about removing HECS fees, you meant to say that nursing courses would be HECS exempt?

Dr Race—Yes.

Senator TCHEN—Because no course is totally free in Australia.

Dr Race—No, but that proposal was put by some, and we were quite concerned by the impact that that would have on us.

Senator TCHEN—Thank you.

Prof. Cameron-Traub—The school of nursing in Queensland has had a very large demand for places and, consequently, no difficulty in taking about 130 full-time students each year. Regarding the school of nursing in Victoria, the Ballarat intake, as I think I mentioned, is about 50 a year and the demand is well and truly above that. We cannot always take everybody who is interested in that course, and certainly at the Melbourne campus the demand far exceeds the

number of applications or first preferences for that course. I believe that is in our submission. In New South Wales, the demand for nursing places has been at a lower level for a number of years, and I am sure you have plenty of evidence on that. It is now, I believe, showing an increase, which is why I was able to allocate more EFTSUs to the bachelor of nursing course in New South Wales this year compared with previous years.

Senator TCHEN—That is very good, because it can give us a comparison across the states as well, from one source. What about the enrolled nurse area? From the TAFE area?

Dr Manwarring—For the past 17 years enrolled nurse education has been delivered through a contractual arrangement with the department of health. The enrolment numbers were based on work force planning needs, and it was up to area health services to determine the numbers of students they would require to meet the ratio between registered and enrolled nurses to deliver health care within each area. Numbers were then based on work force planning needs.

As of this year, the New South Wales TAFE will not have the monopoly of enrolled nurse education. The Nurses Registration Board Act has opened the delivery of this training to other registered training organisations. This will mean that, where there has been a high demand to get into the course, students will now be able to get into other courses that, up until this year, they were not able to enter, due to the contractual program and the work force planning needs I have just identified.

CHAIR—What other courses or other places?

Dr Manwarring—Registered training organisations will be able to submit their educational programs to the Nurses Registration Board for approval, and then they will be able to offer enrolled nurse education as a registered training organisation, through their organisation.

CHAIR—I think I know what we are talking about. We are not talking about the universities?

Dr Manwarring—No, but they may also offer that training.

Prof. McCallum—We are registered training organisations as well as—

Prof. White—But there are some independent private ones.

Prof. McCallum—I want to make a comment of caution in predicting a renaissance or a decline in nursing numbers. There are annual fluctuations in numbers that occur for a variety of external reasons in Sydney. The Olympic year was a hard year to get students into nursing, because of all the external employment. A tight labour market will provide a good year. The fact that all universities were cutting their overenrolment last year has increased UAIs in everything in New South Wales this year. As well, in practice, particularly in nursing, universities have direct and alternative entry schemes, and so UAI levels can go up, simply because you take in more people through alternative entry schemes. I am just saying that there needs to be a note of caution. You need to look at long-term trends, and they are down still.

Senator TCHEN—In other hearings we have heard that in other states there are quite often insufficient places to meet the demand for people wanting nursing training. Do you have the same experience in New South Wales? Professor Cameron-Traub has said that, from her knowledge in her institution, across Queensland and through to Victoria there is a variation between the states. Do you have any comments on intakes in New South Wales? Do you see a demand for places which significantly outstrips the number of places available?

Prof. McCallum—I really should not repeat what Professor Daly has said, but this year was a good year for recruiting, generally speaking, across all courses including nursing. Professor Daly's point was that, if you have alternative models of nursing education which are supported, you can think about substantially increasing numbers.

Senator TCHEN—Asking the question from the other end then, do you think there is a satisfactory output—I should not use the word—of nurses through the institutions? Are you meeting the market demand for trained nurses? I have in mind that in medical training, for example, the institutions now very closely and tightly mete out the number of doctors who get trained. They are very strictly meted out in fact. Do you see the same thing in nursing?

Prof. Daly—Work force planning is a very complex area, and the chief of nursing in New South Wales would say that we do not meet the target that was agreed in 1994 of 2,500 a year. But we probably come close to 2,000. The problem is keeping those new registered nurses in the work force, and that is a major issue.

Prof. White—That is an issue that I would seek to raise too, in that seeking to put more students through nursing education programs almost becomes a moral issue when we know what the attrition rate is like when they enter the work force and when we look at what the work environment is like in some of the institutions. I feel sure that you have heard from other submissions that it is the nurses who are working on the wards at the moment who are telling people not to go nursing, because the environments have been so damaged by all sorts of health services management issues rather than nursing issues.

I would refer you to the submission that we made, where we suggested that in fact this was not a nursing crisis. Nurses are very sick of being blamed for the situation that exists in health care institutions at the moment. Nursing education, more particularly, is sick of being blamed for this situation. Admittedly since 1980 with the pilot programs, we took a bit of a swing away—and I think our submission shows that—into a slightly esoteric area that did not meet needs, but we have moved back since then. I believe that the AUTC project that has just been finished—and the report is available this week—has done a very thorough examination of the nursing curricula across the country, and they are of a high standard and they are meeting service requirements. The issue is not predominantly one of education, even though of course we accept we can do better.

Senator LEES—Is that report you mentioned available this week?

Prof. White—Yes. I spoke to them yesterday at DEST to see if it had been made available to you, and they said that they believed it had not yet but it is available this week. They are very happy to—

Senator LEES—That leads into my next question. As I move around, particularly nursing homes, I hear anecdotal reports that they have applicants who have done no aged care, basically, during their three basic years.

Prof. White—Might I respond to that. If one looks at the average age of people who are in the acute care facilities, almost all the education that the nurses receive these days is aged care. The people who are in our acute facilities are predominantly multipathology older people, often dementing. The complexity of the people who are in acute care facilities at the moment is quite staggering, and I think that really has to be borne in mind when we talk about more students going into clinical facilities and more clinical time. We are busting these clinical facilities at their seams at the moment because of the decreased length of stay and increasing complexity and acuity of the patients that are there.

Senator LEES—Putting aside what is in this report—we do not know what is in it yet—the experience of students at your various institutions would range across what? I am interested from first year. There are in your submission some bits and pieces; I am just trying to put those together in a bigger picture. Roughly what type of experience would they have in the first year? How long would they spend practically out on the wards? Again, could you talk to us about, unfortunately, some of the negatives at the moment: what are some of the problems for enrolled nurses or nurses heading for the degree course? What are those initial experiences they get as they go out for their first lots of practical work? Perhaps we can start at this end of the table.

Prof. Daly—I should just tell you that our school is in the second year of its life, and the University of Western Sydney underwent a major restructure which they started to implement at the beginning of last year. So my task last year was to take three separate schools of nursing with three separate undergraduate courses and to create a new undergraduate course. We did that in the first six months of the school's life. The University of Western Sydney used to be made up of three network members: UWS Macarthur, UWS Nepean and UWS Hawkesbury. It is now centralised and unified and it is one UWS. So our school at the moment is running four different undergraduate courses. We inherited three and from this year we are implementing a new one. Prior to all those changes, I was at the University of Western Sydney Macarthur and was head of nursing for five years there.

To give you an example, the Macarthur course had about 22 weeks of clinical and the new course has about 22 weeks of clinical. The students are exposed to a range of areas. In year 1, they have four weeks of clinical: one in aged care and three in medical-surgical. In year 2, we try to give them a week in drug and alcohol, two weeks in medical-surgical and a week in skills' development consolidation, which could be in a range of clinical areas—it depends on where we can find places—and a week of respiratory nursing and a week of cardiac nursing. In year 3, we have a week of high dependency nursing, a week of oncology nursing, two weeks of skills' development and consolidation—and again that could be in a range of medical-surgical areas—and one week of developmental disability nursing and one week of mental health nursing. They then have a four-week block elective, where they can select the area they want to be in, whether it is high dependency or oncology and so on.

We have a lot of trouble finding enough adequate and quality clinical places. It is very hard to find clinical places in the drug and alcohol area in our region of Sydney. It is very hard to find in-hospital placements in mental health. Most of the mental health hospitals have been closed

down by the government. It is hard to find opportunities to give students experience in working with community mental health nurses, because they are thin on the ground and we have a large number of students. Some facilities have very good intentions. They might be small private surgical hospitals or small private psychiatric hospitals, but they limit the number of students that they can take over time. That is a trend we are witnessing over time, because they have restructured and downsized.

We try to send our students out with one clinical facilitator-educator person to eight students. We were able to do that for quite a few years, but we cannot seem do it any more. The hospitals cannot take that number of students in particular clinical areas. The ratio is now more like one to four, and in some areas it is one to two. We have big problems at UWS in providing all students with opportunities to develop clinical skills and experience in paediatric nursing. The new children's hospital is a facility that is used by all the schools in metropolitan Sydney, and they just do not have places. They are short-staffed, and it is almost impossible for us to get places there for our students. Maternal and child health is another area where it is very hard to get student places in the undergraduate program. They have been re-engineered too, and it is difficult enough to get experience for our postgraduate student midwives. The scale of change is just massive. Women go into hospital, have a baby and are out within 24 hours or 36 hours. Ten years ago they would have been there for three or four days. With student midwives, postgraduate—

Prof. White—Three years ago.

Prof. Daly—Three years ago: I stand corrected. Pupil midwives are having trouble gaining experience and developing knowledge and understanding of managing wounds post-episiotomy because people are put through this amazing system where the throughput is very rapid and then they are back home in the community.

CHAIR—That is extremely useful for us but if everybody is as useful as that we will not be able to stop before 5 o'clock. We have to ask for a time restriction because I would also like Senator Lees to have the opportunity to get a contribution from others in answer to that. Professor White, can you practice that kind of precision?

Prof. White—I will give a quick version.

CHAIR—That would be very useful, thank you.

Prof. White—We have turned our curriculum on its head and, instead of having aged care at the beginning, which many of the curricula across the state have done in the past, we have pulled that out because it was giving the students a very negative opinion of aged care and they were not skilful enough to deal with the complexities of aged care. Three weeks into our program, they are out working in medical-surgical units.

I want to come back to something I heard earlier this morning about observation visits. Observation visits would frustrate the daylights out of our students if they were at the end of the first year. By that stage, they are in there doing, working as nurses. They are well past observation. In first year, they have some days a week in the same facility: they have ten days in the first semester, four weeks in the second. They have two blocks of four weeks in second year.

In third year, we have developed a different program of clinical development units where the staff of the unit take on the students, and our facilitators, who used to look after the students, now help with evidence based practice and development of practice for the staff.

So it is a different investment. It is an investment in having the student in the same place for a longer period of time, owned and socialised in some ways—that used to be a dirty word—into the work environment, so that they are more work ready. In third year, our students come to university for a week, go out for five—same place, same context—come back for one and go out for six. That means 11 weeks of each of the two semesters in third year are spent in clinical environments, and that is working wonderfully well.

The Nurses Registration Board mandates the sorts of experiences that students have to have. They have to have developmental disability, aged care, mental health care, medicine, surgery, et cetera, so you will not find a program that does not go to those places. What you might be hearing is that they are not going to the places they used to go to. You have many aged care facilities that used to have hordes of first year nurses going out and doing sponges and things that they felt were helpful, but they were not necessarily doing the right thing either by the students' understanding of aged care or by the aged care people in those facilities.

Dr Race—I would like to make a comment in reference to the private sector, where we do a lot of our clinical experience. Some of the pressures that Professor Daly alluded to with the public sector are equally detrimental in the private sector. The registered nurses undertaking the work in the clinical areas do not have a lot of time to take a student with them and do the clinical teaching that is required to build the skills of the student. In some cases, the students will be given tasks which are perhaps low level—for example, doing the observations and the hygiene care. It is difficult to get the students involved in some of the more complex areas of care towards the end of their education, to prepare them for that transition to being a registered nurse.

Prof. Cameron-Traub—We have clinical requirements that are mandated by each of the three state registration authorities. They differ slightly. In New South Wales, we have to abide by the requirements of the New South Wales board. In Victoria, there is a slightly different perspective, and in Queensland, there is a slightly different perspective again. Last year we had a faculty of health sciences review and, while our clinical experience differs between each of the three schools, it has been recommended that we go for the upper limit of clinical experience and be consistent, because that is the only variation in our program across three states. It is a requirement that the students have graduated clinical experience according to the skills and knowledge that they have, that it is closely articulated with their competence and that they also have preparation in nursing laboratories in terms of gaining their clinical skills before they go out into the field.

Mr Brown—I would like to remind you that the students at TAFE are employed for a 12-month period by an area health service and they return to that area health service for their clinical exposures. They typically start at TAFE and do eight weeks of theoretical input. During those eight weeks, they have single clinical days in accredited facilities, facilitated by a TAFE teacher. Failing an available place, those clinical days may take place in a simulated clinical environment.

CHAIR—What is the teacher to student ratio?

Mr Brown—It is one to eight.

Senator LEES—What kind of nursing would the students be doing in the area health service—some would be community nursing and some would be other things?

Mr Brown—The next eight to 10 weeks cover their core nursing requirements. These requirements are set by the Nurses Registration Board, as are those for the registered nurses. We are talking about the activities of daily living: hygiene, maintenance and those sorts of activities. The students then return for another six weeks of theoretical input, again with single clinical days through those weeks. Following that, the rest of their 38 weeks of clinical are made up of clinical experiences. They must include medical and surgical nursing, and they must include two other experiences, so in total there will be five clinical experiences. Those two specialities are decided by the employer and are based on service need. They could include aged care, mental health care, paediatrics, rehabilitation, psychogeriatric care, community care and a range of others.

What we typically find is that, because of the high number of nursing homes or private hospitals that are involved with the Trainee Enrolled Nurse Program, we have a very strong aged care focus. Often an aged care facility will be used for the initial eight to 10 weeks, and then the student may well find themselves back there to focus on the psychogeriatric aspects or the rehabilitation aspects. So they may well visit the same facility or even the same ward but with a different focus on their subsequent visits.

Senator TCHEN—I think I am up to Professor Race. Is the nursing education sector meeting the demand of the market for nurses? Could you give just a quick answer.

Dr Race—The hospital that I am associated with would say no. We had a meeting just last week to discuss some of the issues related to why graduates do not want to stay in the nursing work force. A lot of issues that are not educationally related came out of that meeting. There are a lot of issues related to the transition from being a student to being a registered nurse—the support that is given to students and the demands that are placed on them right from the start—that make them choose alternate careers.

Prof. Cameron-Traub—I think it would be very difficult to meet the demand for a number of our places at Australian Catholic University. We could take far more students in at least two locations, and it is just not possible. I would prefer to say that we have the potential in Australia to meet a far greater demand for nurses than is currently—

Senator TCHEN—Is the market demand being met?

Prof. Cameron-Traub—Are you talking about the student demand for places?

Senator TCHEN—No, I am asking about whether, from a nursing training institute's point of view, you are producing enough nurses to meet the market's demand?

Prof. Cameron-Traub—I think the point was made earlier about the problem with nursing work force projections. Again I am looking at three states. I believe we are meeting demand in Queensland, but I stand corrected if there is some data around. In Victoria, I think we have difficulties in meeting the work force needs, and also in NSW. But I have no statistics at the moment to be able to answer that question more accurately.

Dr Manwarring—Yes, we are meeting the work force needs for enrolled nurse support within the area health care services that are involved in the program. However, there is an issue about aged care. Aged care facilities would like to have more enrolled nurses. However, enrolled nurses do not give out medications and, for that reason, their viability to work within the hostel and nursing home areas is limited at this point, and so they are not employed at this stage. But I think, with the review, a number of changes will take place to education and training.

Senator TCHEN—Dr Manwarring, I put this question to Ms Onley earlier, and she suggested that you were the best person to ask. In her submission, she recommended that the scope of practice of enrolled nurses should be re-evaluated. Can you talk on that issue and explain your point of view and how the role should be expanded?

Dr Manwarring—At present, enrolled nurses are not able to give out medications. They can check medications but they do not give out any schedule 2, 3 or 4 medications within the workplace. They are also limited in a number of other aspects; they can do simple dressings, but when it comes to more involved procedures, those fall into the area of the registered nurse.

One of the issues being looked at with the review of the ANCI competencies at the moment is the scope and practice, and I believe that will increase to include the possibility of medication administration up to schedule 4. However, I do not know the outcome of that review at the moment. As Ms Onley may have mentioned, AINs and PCAS—particularly, personal care assistants—can give out medications without any regulation. So, to meet the work force demands, they are employing more untrained people or people with certificate III to give out medications. I believe that, if the scope of practice increases to include medication administration up to schedule 4 by enrolled nurses, then more enrolled nurses will be employed by the aged care sector.

Senator TCHEN—Would the single model nursing pathway that you proposed solve some of these problems?

Dr Manwarring—In the single model program I proposed, where the first year articulates straight into the second year of the undergraduate program and students can exit as enrolled nurses, I would incorporate medication administration and I would also increase research skills and analysis and critical thinking as part of two modules that would be addressed at the end of the education program to bring them up to that level, so that they would be able to work effectively within the aged care sector and also then articulate into undergraduate programs. These are the areas that have been mapped against university programs and these are the areas that have not been addressed with our own. You need to keep in mind that we are very much under the mandate of what is required and set out within the Nurses Registration Board regulations, and we follow those.

Senator TCHEN—Professor White, you say that UTS proposes to pilot a program to incorporate enrolled nurses into the Bachelor of Nursing program which has been rejected by the Nurses Registration Board of New South Wales?

Prof. White—Initially, it was rejected. It was a recommendation of the Reid report, and when I started as dean it was one of the things that the Chief Nurse of New South Wales challenged me to pilot. It was not possible at that time. We are about to try to do it again. I think the climate has changed radically since then. We have also decided that we will do it after 18 months instead of after 12 months—so after the first semester of second year. It is our belief, having done the mapping exercise with the competencies for enrolled nurses, that all the students who have passed their exams at that stage will more than meet the competencies of the enrolled nurses. It will enable students to have employment in health services through the next 18 months of their program, rather than in McDonald's or Grace Brothers. It will also help with things like the winter bed strategy. The June-July break is the time when we need the students in hospitals. That will be cheaper for the government because it is not paid.

Senator TCHEN—Is that a confluence of your ideas and Dr Manwarring's ideas?

Prof. White—I do not see that they are necessarily in conflict. I see that they are complementary parts.

Senator TCHEN—I said confluence, not conflict.

Prof. White—Yes, I know. I do believe that there is a confluence, but I think that there are some people who would not see them as complementary. I think it depends on where you are standing. Certainly, what we would never suggest is that the universities would undertake EN programs for students who only wanted to be enrolled nurses. What we are talking about is students who have made the decision to become registered nurses but on that path are recognised as having enrolled nurse competencies and, therefore, gain an ability to get extra employment in that sector on the way through.

Senator TCHEN—Once you have programs like this running, would you also consider fast tracking the programs of people with enrolled nurse status?

Prof. White—They are already. We have 91 new students in this year. If they have their certificate IV, they come in immediately and do a two-calendar-year program to become registered nurses. That exists; it has done for quite some time.

Senator TCHEN—Can I ask the representatives of the other tertiary institutions what their view is of the UTS proposals? Perhaps I can ask Professor Cameron-Traub first.

CHAIR—Excuse me, I just noticed, Senator Tchen, that Professor Daly wanted to make a comment, so can we take that first and then go to Professor Cameron-Traub.

Prof. Daly—When Professor White was talking about the placement of students at particular times of the year, she made the point that winter is a difficult time, with patient acuity and bed problems. I am sure we have made this point in our submission, but I think it is a really

important one to make: our students actively contribute to provision of health care, and they do that in a very significant way. That is an important point to note.

Prof. Cameron-Traub—I think the UTS suggestion and the project is very exciting. I look forward to being able to do something like that.

Senator TCHEN—I suspect, Dr Race, you are going to tell us that your course is very much oriented in that direction anyway.

Dr Race—We have no problem with what is proposed.

Prof. McCallum—Could I quickly add that we also have a strong TAFE EN relationship at UWS. It is articulated arrangements that could work a lot better through your sort of proposal in particular.

CHAIR—What is a TAFE EN?

Prof. McCallum—An enrolled nurse through the TAFE system.

Senator KNOWLES—I want to come back to this issue of clinical experience, because I think it is terribly important. You have all voiced an opinion about inadequate places. How do we solve that problem? Clearly, as Professor Daly just said, the students make a huge contribution. Even when they are there for clinical practice, they are not there just as a pot plant standing in the corner. How do we solve the problem—and you have all expressed it in different ways—of getting greater clinical experience for the students?

Prof. White—Could I suggest that the assumption that they need it has to be unpacked. I think there is variety across programs, but I think most programs these days have increased the amount of clinical experience that is in their programs. They have pulled the clinical experience forward. We used to have a number of programs where the students barely saw patients until after the first year. I do not know that any of those exist any more. I think what you are dealing with is a lot of feeling in the community that is based on old data. All there needs to be is one student—even one who is only one year out is out of date with what is going on in the universities at the moment.

I would challenge the assumption that the programs need more clinical experience put into them. I think we can do a lot to maximise the quality of the clinical learning while the students are in the clinical environment. One of the issues fundamental to that is resourcing. I am not suggesting that dollars equal a quick fix, but certainly the wards are now so busy that there is not that extra flexibility that used to be seen as a professional responsibility to teach the next generation. When you have eight or 10 patients and you are running just to make sure they are not dying, it is awfully difficult for you to turn around and show someone who is very much a learner through things that one used to show them through. So resourcing into units, adequate staffing of units, would be an enormous step forward to having a better clinical environment for the students to learn in.

Prof. Daly—We are very keen to try to find some resources that would enable us to pilot a sandwich course, where the students would be part of the work force, on shift work regularly. It

may enable us to produce more robust graduates. Certainly, it would sort out those who are seriously committed to a career as a nurse and those who, at the end of the course—and we do have some—still do not really know whether they want to be nurses.

CHAIR—I do not really know what a sandwich course is.

Prof. Daly—A cooperative model. For example, there was an excellent course in New South Wales at the Cumberland College of Health Sciences before the general transfer of nursing education to the tertiary sector. It was a 3½-year course, and a fair amount of each year of the course was spent actually in the clinical environment working as a salaried member of the work force—probably up to half of each year—and it produced excellent graduates. The workplace has changed. For us to try to pilot something like that, we would need resources. We would need to make sure we had quality clinical teachers working in the area. We would need to bring about a change in the mindset of the people who are leading and managing the clinical area at the moment. I have talked to a number of area directors of nursing, and they are enthusiastic about the idea. These students would be on a rotating roster, they would be working shift work and they would be working with experienced nurses, allied health professionals, medical staff and so on. That model is worth further consideration, and it is worth piloting that sort of model.

Senator KNOWLES—What income would they get?

Prof. Daly—The industrial issues existed previously. There was an award that had levels for first-year students, second-year students and third-year students of nursing. The industrial issues would need to be carefully negotiated with the New South Wales Nurses Association in this state and the ANF nationally. From conversations I have had with a number of leaders, there is a real interest in trying to work with that model and trying to pilot that model because it could be the way to the future.

Senator KNOWLES—It is interesting that you mention it, because when we were in Melbourne a few weeks ago we had the opportunity to speak to some of the nurses in one of the hospitals when they joined us for lunch. They spelled out a lot of good ideas, that being one of them. They asked why we did not get some of the students in on a work basis, and then it is mutually beneficial. I just cannot understand why there would be a resistance to it. That is a mystery to me.

Prof. White—I am not against it at all, and I do think it is worthy of piloting. But I think that one would have to be terribly careful about what was actually counted as educational time and how one also has clinical experience which is guided in a way that makes it a more structured learning experience than just being there and working.

Senator KNOWLES—Ensuring that they are not just being treated as lackeys?

Prof. White—Absolutely, yes.

Prof. Daly—Yes. There has to be some supernumerary experience and then some salary work force experience, but we have done it before in this country: we did it brilliantly at Curtin in WA, Cumberland in Sydney and Charles Sturt in southern New South Wales. It is probably a more expensive model but, given the fact that we cannot get registered nurses now, some of

those positions where the money is there for them in the work force could be taken up by students.

Dr Race—That is not unlike a model that we have had for some time. The issue of supernumerary experience versus work force needs is a very real one—giving the students the value of clinical practice whilst they are employed to work. It is difficult to juggle the demands of the workplace and their learning demands. Certainly the workplace sees the work force demands as having priority. In our experience with students, they will often be placed on some of the more awkward rostering shifts like night duty. Unfortunately, that is the time when the support is least, and that is also the time when they tend to get some of the more mundane routine activities—

Senator KNOWLES—I am sorry to interrupt. That is time also when activity is least, and when people are having a snooze.

Dr Race—That is true also, and staffing is consequently lower. It is a reasonable model but we are finding that because of the changes in the workplace it is not an approach that is as useful as it once was due to the stress and demands this places on staff to support students. There are changing models of care also. They are moving away from primary care models, where one nurse is allocated to several patients, to more of a team nursing approach, where a group of nurses is allocated to patients: one nurse might do all of a certain task and one nurse might do all of another task.

Senator KNOWLES—Professor White, a little while ago you mentioned the ratio of nurses to patients. You mentioned that you might have a senior person looking after eight to 10 patients. Is that the norm?

Prof. White—It is probably a slight exaggeration. It depends absolutely on the context. In intensive care, it is a one to one—

Senator KNOWLES—Sure, but just in general nursing.

Prof. White—I will find you the accurate figures on that, but my sense would be that one to six or one to eight would not be unusual on a general medical ward.

Senator KNOWLES—On a general medical ward as opposed to a general surgical ward?

Prof. White—No, medical and surgical would be much the same. Everything from one to one, one to 10 or one to 20, depending on the sort of almost pastoral care that is being given—not that there are many convalescent facilities any more.

Senator KNOWLES—On that issue, is there also a variation between the public and the private sector on ratio?

Prof. White—I believe so, but I should not comment on that.

Dr Race—I have first-hand experience, and my wife is a registered nurse who works at the Sydney Adventist Hospital. It is not unusual to have six or seven patients each shift.

Prof. McCallum—Senator Knowles, there is also an issue when you come back into the university with the clinical. There are high costs to the coordination of students going out all over Sydney and sometimes New South Wales. It is a very complex task of administration. You then have the costs of paying supervisory staff when they are out there. These tasks are not well reflected in the payments universities get. So as well as the outside costs to hospitals and the need to have good people there, internally, it is one of the cost burdens that a nursing program has to carry that is not well supported through the funds we get.

Senator KNOWLES—That is an interesting sideline to that. I have one more question on the four-year undergraduate course that has been expressed to us as a question mark in previous hearings that we have had: how do you view that?

Prof. White—There has been a push from time to time in nursing for many years now about why we are the only health professional group that has three years rather than four years. I think the even greater danger is the push in New South Wales to make it two years, even though they are suggesting that there would still be six semesters, several of which would be clinical. I think it is quite frightening. But whilst I have no resistance to four years, I do not think it is necessary. I think we have a different group of people who are coming into nursing. I think the reality is that they need to be through and earning money as soon as they can. Unless we are talking about four years as the sandwich program that John was referring to, they are well-educated registered nurses by the end of the third year if the program is constructed in partnership with clinical areas and done well.

Senator KNOWLES—It is interesting because, once again in Melbourne, we had evidence that the educational year is only in effect half the year. Some of the witnesses felt that the remaining half was effectively being wasted, that more time could be spent in clinical exposure—

Senator LEES—That is, when they are earning money. Most of them these days are having to—

Senator KNOWLES—That is exactly right. That evidence was given as well. But some of them said that they would prefer to be able to utilise that time, probably in a sandwich type program, where they do earn money.

Senator LEES—That is the issue—if they earn a decent rate.

Senator KNOWLES—But if they are getting the experience simultaneously.

Prof. White—Or, if they are enrolled nurses, they can earn it independently.

Senator KNOWLES—Precisely.

Senator LEES—So after 18 months, that was what you were saying earlier, they would qualify basically as an enrolled nurse and would get a reasonable amount compared to the other casual sorts of work that they could get.

Dr Manwarring—And that was the rationale behind our proposal as well, that you would have enrolled nurses who could exit and work as enrolled nurses, but you would also have those who finished the 12 months and moved into the second year. It is fairly similar to what Jill was talking about. But ours would be within a 12-month period. They could then undertake the undergraduate program—the university sector—and be working as enrolled nurses and be paid a proper wage to be able to support themselves. This would be an initiative also to make it a much better—

Senator LEES—And with three days a week university requirements, that frees them up for two or maybe three days of paid nursing. From what you were saying earlier, therefore, really what we are looking at is not so much the numbers we are putting through university but the numbers that are disappearing once they finish university and the pressures in a range of situations in the hospitals. We have heard from other witnesses about the level of responsibility. It might be all right to be put on a night shift—it is relatively slow. But the responsibility that then goes to someone who might have been out of university for four weeks to suddenly be in charge—

Prof. White—Senator Lees, I think you will find that, in the AUTC report, one of the segments was looking at the transition. There is quite a strong literature review and quite a lot of evidence in that in relation to that transition. Since the inception of this review there have been some absolutely stunning reports come out from overseas looking at exactly what is going on with health reforms on what they are calling the work environment. I would be most happy to furnish the committee with some of those.

Senator LEES—Senator Knowles was asking before about the fourth year. That fourth year is really a working year. It seems a very critical year in the attrition rate, perhaps because of a supervision requirement or some additional support that maybe should be provided in that year just to get people jumping from university and into that level of responsibility.

Prof. McCallum—Most hospitals do have professional support programs running through that first year out because it is so critical and the experience is so formative in the way people approach the rest of their career.

CHAIR—One of the things that has been interesting for us to think about is the way nurses earn a reputation for quality training and so on. It used to be the old brand loyalty: 'I was an RPA nurse' or 'I went through St Vinnies' or whatever. Nobody has rushed up to me to say, 'I've been educated at the University of Wagga Wagga'—sorry, I hope there is not a university that I am insulting; it is hypothetical.

Senator LEES—There is actually.

CHAIR—Of course there would be!

Senator LEES— It is Charles Sturt University. And they are very good graduates.

CHAIR—We also know that there is a brand loyalty being established in education all the time. A voice has whispered in my ear that the 'san' has got a very high reputation and the staff that come out of it are, 'Oh, one of them'—okay, tick off, big credit. I am not sure if that is

worth $8,000, but perhaps it is, Mr Race, and you can say so. I wondered if you could talk about your model of clinical experience, which you briefly mentioned too. Perhaps we have covered it, in which case you can say, 'Read the *Hansard*,' but can you tell us in a little more detail how it operates? And is it the close association with the institution right next door effectively that makes it work better? You were saying, 'It is not really a problem for us,' in terms of rostering and so on. Could you just give us a few words about that?

Dr Race—Because of the proximity of the hospital—our collocation—when the students start undertaking their clinical practice they can undertake laboratory-simulated practice sessions and then move into the real area and start working with patients fairly quickly. That is the program that we have: they move from simulated areas to practice areas and back to simulated to practice as their skills develop. As the course progresses, the extent of clinical that they do increases, and that is common to most programs, but what we also do with ours is that they undertake experience in just about all of the acute care settings that are possible. They can go to intensive care, operating theatre, emergency care, aged care, and rural and remote but to a lesser extent because of the distance issues. We also structure our program so that they can undertake paid work outside of their educational program by having classes on certain days a week. It goes back to the model that we have alluded to before of two or three days of classes and then you can work for a few other days. We have been doing that for some time. The students take work as an AIN in the hospital or in fact any other setting. Some of them now work for agencies rather than for a direct institution because they believe they can get a higher hourly rate.

CHAIR—I am not sure that anybody so far has mentioned the interesting word 'agency', but we will come to that.

Dr Race—Do you want me to clarify what I meant there?

CHAIR—I would love you to tell me a little bit about it. What is the highest price an agency nurse is charging these days?

Dr Race—I could not comment on what an agency nurse receives. There are two parts to an agency nurse fee: one that the agency itself gets for placing the person and one that the person themselves receives.

CHAIR—The worst we have heard is up to $200 to $250 an hour charged to the institution, 55 per cent of that being retained by the agency—which, as other people I know would say, is money for jam. Do you employ agency nurses in your institution?

Dr Race—The Sydney Adventist Hospital does and I know that the agency fees, depending on the area, can be quite high. Intensive care, for example, demands a premium because there are fewer nurses who have the training or skills to work in those areas.

CHAIR—Can you give us a clue about what that figure is? If you do not have it, can you take it on notice?

Dr Race—Yes, I can take it on notice. I would only be picking one out of the air and repeating what I have heard anecdotally.

CHAIR—What is that?

Dr Race—A figure that I recall hearing was $1,000 for a shift.

CHAIR—How long is a shift?

Dr Race—I am not sure if that was a 10- or a 12-hour shift.

CHAIR—If you go on 10 hours, that is about $100 an hour.

Dr Race—It would easily be that much, because I know the hourly rate that was reflected was over $100.

CHAIR—Does anybody want to comment on that?

Prof. White—If I could comment in relation to agencies: I think it has been one of the most pernicious things in nursing. But it is not surprising, because I do not believe that it is about the money. I do not think that nurses are voting to go to agencies simply because of the money. When one gets to a situation of desperation, yes, the money becomes important, but what nurses really want are better working conditions. When they have to take the moral dilemmas home every night about a group of patients that they may not have been able to give the best care for, the easiest thing to do is to say, 'I am not going to belong there anymore. I am going to work when I want to and I will go home with a clear conscience because I have done what I contracted to do. I will work for an agency.' I believe that is the view of the majority of nurses who are now working for agencies.

CHAIR—Could any of you provide the committee—again, only if you can, and easily—with information about agency fees. Strictly that should not be in questions that we put to you, although, Professor, you might have some information. We have heard that nurses from Western Australia were going for a week or a fortnight block to Melbourne and the cost being charged to the institution was $250 an hour—55 per cent being retained by the agency. The Victorian government has now effectively banned the use of agency nurses in their hospitals, which will save them $20 million a year. That is a very large sum of money. I do not know how much it would be, but I presume that private hospitals would have savings too if they did not need agency nurses.

Prof. White—One would hope to reinvest in the nursing work force, but I fear not exclusively.

CHAIR—I thought that was a very interesting comment.

Dr Race—I want to add to what Professor White mentioned about why nurses use agencies. Our students go to an agency for reasons of convenience as much as anything. Apart from the money issue, they can choose their shifts and choose how much they want to work. There is very much a casualised nature of student AIN work in hospitals. Students are cancelled or called on at short notice. Students sign up with an agency to avoid some of those issues. They know they are less likely to be cancelled at short notice, so they can guarantee their income. That is very important when your income is minimal.

CHAIR—I want to move to something you raised in your opening comments, Professor, and that is the cost of clinical education and value adding. I am not quite sure that I know what 'value adding' means. Before I go any further, what is patient acuity?

Prof. White—How sick they are and how much work is required to nurse them.

CHAIR—There seems to be a kind of transference. I did not understand 'acuity' to mean how sick patients were but perhaps how skilled the nurses had to be to deal with them. Am I understanding that correctly?

Prof. White—Yes, you are.

CHAIR—If I am a really sick patient I have high acuity?

Prof. White—You have high acuity.

CHAIR—This session is rearranging the English language for me!

Prof. McCallum—And there is 'fast throughput'.

CHAIR—I particularly like 'using preceptors to upskill people'. I would love it if you would talk to me about preceptors upskilling people. But the point you were raising before, which is the cost of clinical supervision by universities—which is not adequately funded by the universities—is not too different from practical experience for teachers, as I understand it from education departments. Would you like to talk about how you can have a paid university person looking after students, and then, when they graduate, they may have a preceptor—not paid by the university—supervising them in their clinical area. This is a bit dramatic.

Prof. McCallum—I referred briefly, in response to Senator Knowles, to the sorts of costs that are incurred by universities in providing clinical education for nurses. You are required to provide more or less full-time staff who are doing the placement and organisation of students going out on clinical placements. It is an extremely complex job. It has become harder as hospitals have become busier and placements more difficult to get as the competition for those placements has increased between universities.

As well as that, you have the people in the field, who are with the students, who you also pay. That is the one to eight ratio; you are paying one person to go out with those people. Within our university, the resource allocation model, the RAM, allocates 1.7 to nursing—that is 1.7 of about $3,000 so you are getting about $5,100 per year for your nursing student. If somebody was doing entirely science subjects, they would get 2.1, which would give you about $6,300 and that relates to the laboratory work. It is the clinical component of nursing which is very hard to get recognised and, because universities are under stress in terms of their payments, it is not easy to get through.

The second part that you asked me about was value adding, and Professor Daly referred to this earlier. When you are taking in students with UAIs of 60 and above, some of those students have poor English expression and comprehension and you invest in that. The second area that you also need to invest in, particularly with young women coming in, is mathematics. We have

identified something that really is a mathematics phobia—it is not just poor education in mathematics, it is an emotional resistance to it—and we have a range of programs to deal with that so people can do their calculations of drugs at the end of the bed and get them right. Students are perfectly competent in every other area of their life, bar their fear of doing those numbers.

Senator KNOWLES—It would be pretty dangerous if they make too many mistakes.

Prof. McCallum—It is extremely dangerous and you really do have to get that right or not ask them. What I am signalling is that, at the level of entry where we take nurses in in most Australian universities, there is a significant extra investment in value adding to education that, again, is not covered in the basic payments you get for nursing.

CHAIR—How do you talk to nurse employers, particularly about the changes you see as necessary in the curriculum?

Prof. Daly—We have external advisory committees for our courses and we have to have representation from the service areas that we deal with on those committees. So they are actively involved. Each time we have to do a new version of the curriculum, we involve them early on and they work with us on that.

CHAIR—Professor White, you have talked about the significant increase in clinical experience. It will shock you that the evidence given to us shows that is not the way it is all across Australia. You certainly indicate that it is a good way to go. Did you do that in response to what people were saying was insufficient in the previous curriculum?

Prof. White—Absolutely, and by listening to our industry partners and to our students, and it also came from our educational philosophy. It was a response, but it has worked well. We were trying to cut out the middle man in some ways. One thing that has happened as university programs have grown is that there has become a breed of people called clinical facilitators or clinical educators who take the students out into the clinical arena. They have become quite costly beasts, but they are not really owned by the university and they do not really belong to the university. Nor are they owned by the clinical facilities. So we looked for a way in which we did not have to use expensive and sometimes inappropriate university staff to be doing the clinical teaching that registered nurses could do. We had to do it by using the money we would have paid to clinical facilitators, to pay to the wards so they could get extra staffing, go to conferences or whatever they wanted to do, so that they saw they were valued for their input in teaching and that it was not an extra burden on them.

Speaking to John's point for a moment, it was never adequately costed when the transfer of nursing education took place. If you look at the funding for veterinary science, for agriculture or for medicine and you look at the funding for nursing as a practice focussed discipline, we are wildly underfunded, but we did not want that to be the first thing we said when we came to the review. It is about all sorts of other things; it is not just about dollars.

Senator KNOWLES—Do you have any statistics on the travelling funds of all of those other disciplines vis-à-vis nursing? Is it in graph form that would be crystal clear?

Prof. White—The figures come from DEST every year in terms of what they get per student head and what we get. We are in a completely different band.

Senator KNOWLES—So you used to be?

Prof. White—No, we have always been. We were put in an inappropriate band when we started and we have never been moved from that band. They are very interesting comparisons to make.

CHAIR—The Catholic University has different state campuses. Do you have a single advisory committee doing curriculum, or do you have to go through the advisory committees in each state?

Prof. Cameron-Traub—No, we have a faculty wide approach to all course development now, regardless of which campus it may or may not be implemented on, and that includes course development committees or course review committees which involve stakeholders—representation from employers, students and potential clients. That is all done on a national basis. The implementation of a particular course into a particular campus depends on things like demand and relevance, and the contextual features are taken into account. We would not be at all keen on having a different course development or course review process in each state. However, after all of that ACU development and review is done, we have to take particular courses to the state based authorities, such as the nurses registration boards, for their formal approval.

CHAIR—We are now past time, and I thank you for your generosity, but what is your view on the national curriculum? This is interesting—to this point, there has always been a big yes for national curriculum.

Prof. White—The AUTC review clearly says that there is no evidence of the need for a national curriculum. We have ANCI competencies. They are expressed in different ways in different curricula, but they each meet the appropriate nursing registration authority standards and there is a real need for university curricula to be able to have local flavour. That is a really important point from which we do not budge.

CHAIR—Is national registration of any interest to you at all? I see it is not your area of concern.

Prof. White—It would be very difficult, given that accreditation is state based.

CHAIR—How does TAFE talk to the universities and how do the universities talk to TAFE?

Dr Manwarring—I am on a number of committees. I worked with the University of Western Sydney through the Greater Western Area Sydney Nursing Alliance and we have regular meetings. I also work with all area health services through management meetings which we conduct three times a year at each area health service to discuss changes or policy changes in nursing. I work with the Catholic University. We have regular meetings looking at the bridging course, and any updates or changes to curriculum are then made within our bridging course. I work with Newcastle. At the moment we are working on online development for our bridging

course. I also have met on a number of occasions with the University of Technology, Sydney to discuss issues related to what Jill had raised earlier—the 18-month course and the recognition of students who leave the undergraduate programs. I am also on the ministerial standing committee for work force planning with the health department. I believe our relationship is very good—

CHAIR—But there is a problem.

Dr Manwarring—and they are always involved in any accreditation process, which is part of our requirement for enrolled nurse education changes.

CHAIR—They are starting to lose quite a lot of very formal capacity to talk between the state-funded and the Commonwealth-funded education institutions. One thing we have not talked on much, and it is quite interesting, is re-entry. There has been a lot of evidence given to us that the biggest dropout area is the first year out when they hit the wards and, to quote somebody, they are gobsmacked. In the light of what you have been saying about the changing of course here and much more clinical experience, one could expect that that would be lessened. Also, we have been told that sometimes those RNs are the only permanent staff on the ward, so they find themselves supervising agency staff or other part-time staff who are even more qualified. This is a pressure which may be a factor that we cannot easily dismiss. The other problem is that in Victoria there are 70,000 registered nurses and 50,000 working—20,000 lying around there, waiting to be caught up. I do not know if you have the figures for New South Wales that you could help us with.

Prof. White—Judith certainly will this afternoon, because she has just introduced a Nursing Re-Connect project on behalf of the state government.

CHAIR—Maybe we can leave our questions until then. If you have some dot points that you really wanted to put to us, that would be good. Again, one of the problems for a lot of people was that re-entry, as apart from postgraduate, often required going outside hospitals or where clinical care was needed. A lot of people found it was a big offput to have to do university training. Is it provided in both universities and institutions, or only institutions?

Prof. White—In New South Wales now it is only in institutions. Whilst it is getting a bit of a positive spin at the moment, because of elections, there are real problems with it. There are people coming back through the Nursing Re-Connect strategy who have been out of the work force for, often, 10 years and up to 30 years. We have had people ask where the syringes are when they are standing front of them, because they were looking for glass syringes. They are people who would not be given any advance standing back into undergraduate university programs, and yet they are being brought back in as a desperation tack into the hospital environment. I believe there are much better partnerships that can be made with re-connect strategies, and I think they must be with universities. We are the best judges of work-readiness at the end that is equivalent to registered nurse status. But it is not happening in New South Wales.

Prof. Cameron-Traub—I believe the ACU made quite a lengthy representation about re-entry, and indeed we were of the opinion that it would reside much more appropriately with universities.

CHAIR—We have taken a lot of your extra time and your tolerance. If you there is anything else you would like to have said, please feel free to provide it to the committee.

Proceedings suspended from 1.17 p.m. to 1.53 p.m.

MEPPEM, Miss Judith Louise, Chief Nursing Officer, New South Wales Health Department

DENT, Ms Janice Patricia, Executive Director, New South Wales Nurses Registration Board

DYER, Ms Kate, Deputy President, New South Wales Nurses Registration Board

CHAIR—Welcome. The committee prefers that all evidence is given in public but should you wish to give any evidence in camera you may ask to do so and the committee would give consideration to your request. I am advised that I have to remind you that your evidence is protected by privilege but the giving of false or misleading evidence could constitute a contempt of the Senate. I am nervous about saying that because it suggests that you might be so minded. The committee has before it your submissions Nos 867 and 296. Do you wish to make any alterations to your submissions? As you have indicated no, would you like now to make an opening statement and then field questions.

Miss Meppem—Thank you for the opportunity to appear before the committee. New South Wales Health supports the Senate inquiry as we all continue to address the issues surrounding the recruitment and retention of nurses, recognising that they are quite complex and all interrelated. New South Wales Health believes the Commonwealth has a strong role to play in addressing the issues in partnership with the states and territories. We believe it is particularly relevant for issues around undergraduate and postgraduate education including access and cost, provision of accurate and timely information, national work force planning, marketing and promotion of nursing as a career choice, and national coordination. As outlined in our submission to the inquiry, the recruitment and retention of nurses is a very high priority of the New South Wales government, evidenced by the continuing emphasis on a whole range of strategies around recruitment and retention, education and promotion.

In addition to the strategies identified in attachment 3 of our submission, there have been some significant recent initiatives implemented primarily as a result of the major research project we undertook into the nursing work force in 2000 and the ongoing work of the New South Wales Ministerial Standing Committee on the Nursing Work Force. I thought it would be appropriate for me to outline some of those initiatives.

Firstly, Nursing Re-Connect was launched by our minister in January 2002 to attract nurses who have been out of the work force for some time back into the nursing work force. The initiative has changed the traditional structured model of a refresher program, which was evident in New South Wales, to one of a paid, clinically focused, individually tailored and supported re-entry to the nursing work force—so based on what individuals need, not on the same thing being needed for everybody. This re-entry is both into general wards and our specialty areas. The results of this initiative to date have been very encouraging. We have received over 2,000 calls to our 1800 number. In the first three weeks of the program, of the 1,500 calls we had received, 600 are considered to be potential leads already, approximately 300 have been employed and are back in the system or are about to come back into the system. We did not want to create a staffing issue in the aged care or private health care sectors so our

initiative is primarily for nurses who are not in the nursing work force anywhere in New South Wales.

The second strategy is related to access to education. Given that the cost of undergraduate and postgraduate education is impacting on enrolment numbers, our minister continues to call on the Commonwealth to waive both HECS and fees for nursing education programs. To assist in regard to cost and access to education the New South Wales government has significantly increased funding to the New South Wales Nursing Scholarship Fund for 2002 to provide more scholarships.

In our submission we mentioned the fact that there is no research in the Australian context that analyses the impact that nursing work loads, staffing levels, patient acuity, and the different nursing skill mix and models of nursing care have on patient outcomes. These are issues that have come out time and time again in New South Wales, including through our major research project, as impacting on retention of nurses. Unfortunately, New South Wales was unsuccessful in our submission for funding through the Commonwealth-state priority driven research program to have some research done in this area. However, we believe it is very important research that needs to be done and so we are progressing it ourselves. Five other jurisdictions have now also indicated their interest in being involved and the office of the NHMRC will be managing both the EOI and the scientific merits selection processes for this research.

The matter of security and violence in the workplace is of particular concern to the government and the health department. The minister has established a taskforce that is widely representative of the health system, staff, unions, and external organisations that have expertise in this area. The taskforce has been requested to report to the minister regarding additional strategies that can be put into place in New South Wales Health to make the workplace safe.

The minister has also provided additional funding of $10 million to address some of the immediate areas of concern identified at the beginning of the taskforce work. We are also seeking legislative changes with regard to sentencing processes to recognise the impact of violence in the workplace on all our health service staff. There is a whole range of other initiatives—including clinical support, mentoring of new staff, improving working relationships at the workface, a specific Aboriginal nursing project to encourage more Aboriginals to take up nursing, our Nurse Practitioner Project, a review of access to child care and a whole range of initiatives—around what we define as process and practice development which will particularly focus on further innovation at the workface, clinical coordination, showcasing innovative leadership and management practices and enabling changes to the culture of the work environment.

Ms Dent—The Nurses Registration Board supports the Senate inquiry into nursing, and we would like to update and elaborate on the original submission of the board. The submission of the Nurses Registration Board of New South Wales provided the committee with an overview of the numbers of registrants who currently hold an authority to practise nursing in New South Wales and therefore the number of nurses who could seek to be employed in the health system in New South Wales.

With regard to registration numbers over the past six years, the number of graduates of nursing courses in New South Wales who have registered with the board since 1995 range from

1,723 in 1995 to 1,643 in 2001. Over these years, in 1996, there were 1,451 registrations; in 1997, 1,479; in 1998, 1,553; in 1999, 1557; in 2000, 1,351. So there have been some fluctuations in the numbers registering. The submission also outlined the development of comprehensive nursing programs in the higher education sector in New South Wales, accreditation processes and requirements, enrolled nurse education, professional conduct issues as they relate to new graduates and the authorisation of nurse practitioners.

With regard to the information provided about enrolled nurse education, an amendment has been made to the Nurses (General) Regulation which has the effect of enabling other accredited providers of vocational training or higher education, in addition to TAFE, to be approved by the Nurses Registration Board to conduct a nursing course leading to enrolment. At the time of the submission this was not the case, and TAFE was the only provider recognised in New South Wales.

The submission also referred the committee to a major research project undertaken by the board, entitled 'Project to review and examine expectations of beginning registered nurses in the workforce, 1997'. The board commissioned this research in an environment where there were widely differing clues with regard to the readiness of new graduates to enter the workforce as competent registered nurses. The board also recognised that, while there was much anecdotal evidence, there was a paucity of research. The views of new graduates, registered nurses—including clinical staff—nurse unit managers and senior nurse managers were sought, and the research crossed a range of health settings in both city and rural health services.

While this is now five years ago, some of the findings of this report appear to continue to be relevant; for example, the research includes experiences of new graduates, their expected performance on entering the workforce and issues relating to the transition and integration of new graduates into the workforce. With regard to learning experiences in the preregistration program, the report addresses some of the issues relating to clinical experience and states:

> While the duration of 20-26 weeks over the three years may be an adequate minimum of clinical experience, the quality of students' learning experiences during this time is paramount.

The study also notes the perceptions of new graduates and experienced registered nurses employed in the health care sector at that time:

> Perhaps the most revealing finding in this area was the contrast between the optimism expressed by the majority of new graduates and pragmatism, or possibly even cynicism, implied in the responses from the experienced nurses. While two thirds (65%) of the new graduates indicated that they expected to be satisfied with their job as registered nurses and only 6% expected not to be satisfied (the remaining 29% being unsure), only just 35% of experienced nurses expected new graduates to be satisfied with their new jobs while equally as many (35%) disagreed or strongly disagreed with the statement that new graduates would be satisfied with their job as registered nurses.

The report goes on to say:

> It is not clear whether such negative expectations lead to positive actions in order to convince beginning registered nurses that nursing work can be satisfying, or whether they in some way contribute to a 'self fulfilling prophecy'. In the latter case, new graduates would be expected to find nursing unsatisfying in the pool and therefore wishing to leave it, thus confirming the perception that the problem lies with new graduates, rather than with what happens to them in the initial months of employment.

Finally, I would like to elaborate on the outcome of the seminar referred to in the submission, which the board convened following the research project. The board was undertaking a review of the requirements for courses leading to registration and the draft document 'Guidelines for the development of programs leading to registration as a nurse in New South Wales'. Two major themes emerged from the seminar. These were: the need to establish effective partnerships between health services and educational institutions and the advantages of a more flexible approach to clinical education. Currently the board has deferred any further deliberations in regard to requirements for courses leading to registration and enrolment until the outcomes of the current government inquiries are available.

CHAIR—Thank you. Are there any questions?

Senator KNOWLES—There are a couple of the things I would like to canvass with both the board and the government. One is the matter of country facilities for nurses. We have had evidence about remote areas. I come from Western Australia, so I have known of the huge problem in getting people out into remote country areas because they are largely treated very differently from the local police officer or the local teacher or whatever. May I ask both of you what the situation is in New South Wales with country facilities for nurses and how they compare with other professions?

Miss Meppem—As far as the government is concerned, the department has been working very closely with our area health services to address some of the issues that you are referring to, to enhance recruitment and retention of nurses into country towns. We had a Rural and Remote Nursing Summit in 1998, where we had all of our rural area health services represented and representatives from the Local Government Shires Association, the New South Wales Farmers Association and CWA et cetera, to talk about these particular issues.

A whole range of recommendations fell out of that summit that encouraged our area health services to work closely with local government organisations to promote the town as attractive to work in, not only for nurses but also for our allied health professionals, and also to look at some of the issues that might be impacting on that, for example, accommodation and the social network, once they get there. There has been a lot of work done over recent years in regard to accommodation. There are problems with available, affordable and suitable accommodation. The government has funded our rural area health services for specific accommodation and issues in that area. The minister recently announced some more funding to address those particular issues.

The Commonwealth puts a lot of money into recruitment and retention of doctors in rural Australia and nurses believe that the same attention should be paid to the nursing and allied health workforce as well. The New South Wales scholarship fund that I referred to was initially established as a rural nursing scholarship fund, but we have extended some of the streams to include metropolitan nurses, particularly in the postgraduate area. Our undergraduate scholarships are specifically for rural people because of the difficulty they have in accessing education. We have also been working with the educational providers to take more education off the campuses in Sydney out to rural New South Wales to make access more easily available.

Senator KNOWLES—Is there a difference in the accommodation standards for nurses vis-à-vis police officers or teachers? We have had evidence that nurses are somehow expected to

share a place. It probably has an even greater effect on them when they are working shifts in a very demanding type of position, whereas the teacher next door has a place for themselves, as does the police officer.

Miss Meppem—Yes, there is evidence of that. There are discrepancies in that area, certainly with nursing. All of our hospitals had nurses homes, as they were called then. Some of them still have them and some of them are refurbishing them to provide short-term accommodation for nurses in particular. Some area health services are moving under the initiatives that I have talked about to provide houses and accommodation similar to that which teachers and police can access. We are working with our area health services to do that.

Senator KNOWLES—How long do you think it will be before they are on par?

Miss Meppem—I could not comment on that.

Senator KNOWLES—Is there a timetable attached to it?

Miss Meppem—Yes. It is an initiative that will go over a number of years until all of the issues have been addressed.

Senator KNOWLES—Does the board have a view on any of the difficulties associated with country practice?

Ms Dyer—As far as the board is concerned, we have absolutely no jurisdiction about the level of accommodation. Certainly as far as making courses, education and things like that available for our rural colleagues, the board for those courses which we do accredit has very favourably looked on creative ways of providing that level of education, from the more didactic level of bringing people into universities through to Internet based courses. The board recently accredited a completely external Internet based course, which is a specific course that is going to be available to everybody, not only in New South Wales. So we certainly look very favourably upon ways in which our academic groups can provide the education without actually having to bring our rural colleagues into a city environment for them to actually access that level of education. Janice, do you have anything you would like to add to that?

Ms Dent—No. In terms of the board itself, it does go out and hold road shows to inform. The board invites the rural nurses to come and be informed of all issues in terms of professional conduct. We do try to involve the rural area as much as possible, so they are informed of what the board's role is and what its responsibilities are.

Senator KNOWLES—What are the retention rates in the country practices vis-a-vis even holiday makers going through and earning a dollar, working for a couple of months in one town and then moving on to the next state or town? Is there a solid, consistent workforce in country New South Wales?

Miss Meppem—Certainly the figures that we have from our rural area health services demonstrate a consistency. Some of the reports we get say that some of the country towns face infrastructure changes, and you might see people moving out. The figures that we get from our area health services have not demonstrated any significant change over recent times.

Senator KNOWLES—I have another question relating to that. Has the New South Wales government made any approaches to the Commonwealth government about immigration issues involving the overseas-trained nurses that would fill any shortages?

Miss Meppem—Yes, we have.

Senator KNOWLES—What sort of response have you had?

Miss Meppem—We have raised on a number of occasions issues around—I think this was in our submission—the working holiday-maker visa and the fact that they can only work for one employer for three months. The advice back from Immigration is that that is the way the visa requirement will remain, due to the Senate inquiry that was held that led to those conditions and rules. However, the immigration department has responded to our request and is working with us in identifying other avenues that are available to move nurses who come into Australia on other visas fairly quickly so that they can be retained in our workforce. We have been working very closely with them over the last four or five months to address those particular issues.

Senator KNOWLES—In general terms, particularly across medical and surgical wards as opposed to ICU, emergency or anything like that, do you have statistics on the patient-nurse ratio?

Miss Meppem—No, that is something that area health services would have information on—we do not keep that centrally. We have not gone down the pathway of nurse-patient ratios. We believe that every practice context is quite different and that they need to look at those particular issues to determine their staffing levels. That is one of the reasons also that we want to move forward on the research project that I mentioned in my introductory remarks, because there is no Australian evidence that demonstrates differences in patient outcomes for different staffing levels and different skill mixes. That is what that research is all about.

Senator KNOWLES—In your submission on page 3 you have listed under the heading 'Other issues', that there is 'relatively little influence over patient activity'. What does that mean?

Miss Meppem—Certainly the patient throughput, patient activity, is not something that nurses can have a great deal of influence over, as that is decided by patient need. That is what that point refers to. If, for example, on a particular shift or a particular day there are staffing issues that need to be addressed, there needs to be a whole series of negotiations that go on with the people who organise the admissions and discharges to make sure that that workload is appropriate. They cannot say, 'No, we're not going to take those patients in.' That is basically what that is referring to.

Senator KNOWLES—I see. I was a bit mystified in reading that and thinking surely the nurses are brought into the loop.

Miss Meppem—Yes, they are. We have seen a lot of development in the area of bed management and patient management over the last couple of years, but nurses certainly still have that perception—which is what this particular issue in the submission is referring to. Nurses are very heavily involved in resolving those issues now on a daily basis.

Senator KNOWLES—What is the board's view on what can be done to elevate the status of nursing? We have consistent evidence that the status of nursing is fairly low, as viewed by the community—who obviously have not been sick. I just find that remarkable. I would have thought that most people in the community would value enormously the role that a nurse plays, but it does not seem thus. What is being done to bring it back to where it should be?

Ms Dent—A number of Morgan Gallup polls have indicated that nurses are seen to be of good character, better than other groups, and it is quite interesting to think that their status does not reflect that in the public eye.

Senator KNOWLES—But the public is being reported in the Morgan Gallup polls. That is why I find they are contradictory to what we are being told.

Ms Dent—Yes.

Ms Dyer—Can I just make the comment—and it is not necessarily on behalf of the board—that, while nurses themselves feel undervalued within their own working environment, it is very likely that that perception will prevail with the patients or the public who resource that work force. Part of the issue within the nursing work force at the moment is that they do feel very undervalued. The Nurses Registration Board are presently doing things such as the road shows. They talk about some of those issues with regard to the sorts of things the board can offer, the role of the board. But, as far as helping the public to see nursing in a different role, it is unusual to hear that they do not see nurses as necessarily a valuable resource, given what we see on the nursing side from the public.

Senator KNOWLES—That is exactly right. That is why we have been a little gobsmacked to hear so much evidence of that being used as a reason why people do not go into nursing.

Miss Meppem—In attachment No. 1 to our submission, we actually make a brief reference to it on page 6. We see this as a major issue. We believe one of the reasons is that it is very difficult to get good news about the extraordinary things that nurses and midwives are doing across Australia into the media.

Senator KNOWLES—Isn't it difficult to get good news into the media, full stop? Just ask us!

Miss Meppem—I think that is one of the issues leading to exactly what you are talking about, that you only ever hear the sensational or the bad news about the one-off things that happen.

Senator KNOWLES—Someone being given a wrong dose and dying.

Miss Meppem—That is right—when you think that in New South Wales, for example, we have 40,000 nurses working in the public sector and 15,000 working in the private sector. Nursing in Australia is second to none. As Jan said, every public opinion poll puts nurses right up there at the top of the pops, yet you only ever hear the bad news. We try very hard in New South Wales to get good news about nurses and midwives into the press, and it is very difficult.

Senator KNOWLES—If what we are being told is actually impacting on the intake and the desire for people to take up nursing as a profession, surely there is something that we need to do collectively to dispel this myth that is going around that nurses are somehow lesser valued in the community.

Miss Meppem—That is why, in our case, we believe there needs to be a nationally coordinated campaign about this very issue—about what nurses and midwives do, the extraordinary things they do and the positive elements about being a nurse. Every state does it on a state-by-state basis, but we believe there needs to be a really big splash with a national campaign.

Senator KNOWLES—I have seen very little done in a positive sense. I think it is quite disturbing in a day and age when any form of authority is being belittled by the so-called media. They will only pick on a police officer if there is a question mark over that police officer, or whoever it might be. Instead of building people up, they are tending to pull everyone down with the sensational stories. I have to say that I have not seen any evidence in Western Australia of any marketing program that could, in fact, attract young people.

Miss Meppem—They had a campaign last year, I understand, that was, 'Are you good enough to be a nurse?' That was a multimedia campaign in Western Australia. For example, we have had a number of campaigns over recent years with different themes. Our current theme is, 'Nursing, you can really make a difference'. The one before that was, 'Nurses, the heart of the health system'. Victoria has had different ones, but similar themes along the way.

Senator KNOWLES—Maybe I do not watch enough TV.

Miss Meppem—Certainly we believe strongly that across Australia this needs to be done at the same time, so it is really flooding all of our media.

Senator KNOWLES—That is right.

Ms Dyer—There are two slightly separate issues, one being: 'Why is nursing not an attractive profession to encourage our young males and females to join?', versus the public's opinion of what nursing is. When we look at the Morgan polls, nurses are considered to be very loyal, truthful, people you would trust, that kind of thing. But that is not necessarily what is going to attract people into a career that is considered to be unfriendly for families, not flexible enough and not necessarily financially viable in the long run. They are two separate things that we need to try to keep apart in the process of looking at how we improve our work force to attract people. There are many more issues that nursing is not seeing.

Senator KNOWLES—It is a total package, isn't it?

Ms Dyer—Yes; it is an absolute package.

Senator KNOWLES—It is very much a total package.

Ms Dyer—Colloquially, many people think nurses and midwives are fabulous but, 'Thanks all the same; I am not going to do that'. It is not about the fact that they are not looked on well. It is the fact that 'I can do better in other jobs, in my long-term career, than I can in nursing'.

Senator KNOWLES—I have one final question: are you aware of any evidence of scores being dropped to get more people to go into nursing?

Miss Meppem—We do not have the final UAI index for New South Wales yet, but certainly the informal advice I have been given has not demonstrated that significantly yet. As I said, we do not have the final advice yet.

Ms Dent—That is an important point, too, because it is at the school level that they perceive nursing to be the last option on the basis of the entry score. It is a very important aspect of promoting nursing at that level anyway.

Senator KNOWLES—The theme of 'Are you good enough to be a nurse?' really needs to be turned into a positive, as opposed to, 'This is your last resort—take nursing.'

Ms Dent—Yes.

Senator TCHEN—Ms Meppem, you said the recruitment and retention of nurses was a matter of high priority. Which aspects are higher, recruitment or retention, in your view?

Miss Meppem—With respect to what we are doing as far as the department is concerned, it is both, but there is a particular focus on retention. It is not easier, but once you get the nurses there, that is the first step; you have to keep them there. Many of our strategies that were in our submission, and the ones that I talked about earlier, are around those retention issues, firstly, making the workplace somewhere where you want to go to work and, secondly, once you get there, somewhere you want to stay. Retention is a particular focus as well.

Senator TCHEN—One of the various things that can be done to help retention is an opportunity for postgraduate education. You suggest that a wider range of models of delivery needs to be developed.

Miss Meppem—Yes.

Senator TCHEN—Can you enlarge on that? What types of models should be canvassed?

Miss Meppem—We believe that there need to be a lot more options for part-time programs, online programs and distance education programs; for example, there needs to be a provider to take the program out to rural New South Wales so that students do not have to travel to a central point. There are lots of ways to deliver education other than in the classroom. We have been working with education providers in New South Wales to maximise that as much as possible, particularly through our contract with the New South Wales College of Nursing, which delivers a significant number of programs on our behalf. Many of those programs are now done off-campus.

Senator TCHEN—The institutions are cooperating with that?

Miss Meppem—Yes.

Senator TCHEN—Earlier we heard from an educational institution about a proposal which seemed to have fairly general approval—I would not say support—and that is a unified single stream of training for nurses, from enrolled nurse through to registered nurse. In your comments about enrolled nurses, you talk about an exit point in an undergraduate degree, which is pretty much what UTS was talking about. Does the department support that approach?

Miss Meppem—We believe very strongly that there needs to be articulation through all educational pathways and that an institution needs to recognise the prior learning that a nurse has received in a previous course. We are also quite disappointed because an exit point as an enrolled nurse was one of the recommendations of the first National Review of Nursing Education. It was never picked up by any of the tertiary institutions and we were quite disappointed that nobody took it up. That clearly needs a new curriculum, and the board needs to be involved as far as enrolment at that exit point is concerned. We believe very strongly that that would be a very successful option, because we have a lot of people doing enrolled nursing and then moving into the undergraduate program to become registered nurses and working at the same time.

Senator TCHEN—I understand UTS made that proposal last year but the Nurses Registration Board rejected the idea. If they propose it again, would the board be of a different mind?

Ms Dent—I do not recall the proposal.

CHAIR—It was from UTS, effectively to allow a second-year student to be ticked off as an EN equivalent—not to actually leave as an EN but to effectively be regarded as having reached an EN level—and then be eligible to work at EN levels.

Ms Dent—I do not recall that proposal, but it may have happened and I just cannot recall it. If a university puts forward a proposal, it is very formal and it has a full curriculum and exit points, so I think I would have remembered it. However, it does not come to mind. When a university puts forward a program, we set up an accreditation committee, the committee assesses the program and makes recommendations to the board. The board has approved a range of different models, including the online one quite recently. I am sorry I cannot provide any insights into that.

Ms Dyer—I certainly cannot remember it, as a board member, coming through in the past 12 months.

Senator TCHEN—Should such a proposal be put up, what is likely to be the board's attitude?

Ms Dent—It would be considered on the basis of what the curriculum contained. It would have to be demonstrated that it meets the competencies, that the students who progress through the program—

Senator TCHEN—I am not talking about the detail but the concept of having a stream which people can enter and exit.

Ms Dent—The board has already approved a number of courses that have bridging programs for enrolled nurses. I cannot give you the board's view, but it considers all proposals that come through.

Senator WATSON—Miss Meppem, I am going to ask you a few questions which relate to the points you raised in your paper—which is, by the way, a very good summary of what we are looking at. In a Senate committee like this, we scrutinise a problem and look for remedies. Then we report to the government and the government goes to its departments to get advice and implement policy. In this case, you represent the department.

I want to ask you about some of those issues you have raised of things that should be done. My question is, what have you done about it? For example, particularly in the state area, not in the Commonwealth area, you suggest that the workplace culture needs to be transformed to assist staff to develop skills, and that again is part of the package to help to retain staff. Has New South Wales Health put any projects in place to transform workplace culture?

Miss Meppem—We certainly have. In attachment 3 to the submission I did outline some of the things that were going on at the time of that submission, which was in June last year. My opening remarks referred to some of the things that have happened since that submission, and certainly those things you are talking about are all embodied in those opening remarks. For example, with regard to making the culture of the workplace more attractive, they are the major recommendations that have come out of the ministerial standing committee on the nursing work force. We have an action plan that is developed moving forward with a whole series of initiatives that will particularly focus on those issues of transforming the culture at the workplace. Nursing recruitment and retention is not just nursing business, it is everybody's business, and everybody—doctors, allied health professionals and administrators—has to work at that local level about turning those issues around to make the environment more attractive for nurses. Rolling out this year will be a whole range of strategies around leadership, management, cultural change, clinical supervision, clinical coordination and making that working environment more attractive.

With regard to the more specific issues around violence and harassment, or bullying, as people like to refer to it—

Senator TCHEN—Horizontal violence.

Miss Meppem—Yes. The department did issue a statement, in partnership with all of our unions in New South Wales, about harassment at the workplace—that it is not acceptable and that there have to be processes in place for these issues to be addressed. That has been circulated throughout the system, and area health services are now working to address any issues that arise. The task force on violence in the workplace is well advanced on a whole range of different fronts about making it a safer place for all of our health professionals. So there is a lot of work going on in all those areas to do the sorts of things that I am talking about in the submission.

Senator TCHEN—On horizontal violence, I asked the question of some other professional representatives this morning because it seemed to me that in such an attention critical professional area there is a need, rightly or wrongly, to weed out early the weakest link, if you like, so there has to be a constant tension there to make sure that everybody is doing the right thing and everybody is on their toes. Could that be part of that reason, and, if you removed that, would that be likely to reduce professional efficiency?

Miss Meppem—I do not think so. The fundamental issue is that everybody should be treated as valued members of the team, whether it is a doctor, a nurse, an allied health professional or any of the support staff. Unacceptable behaviour, harassment or bullying, is totally unacceptable. Employers need to have processes in place that, first, promote a culture like that and, secondly, mean that, if it is a problem and it is happening, people can speak up without fear of recrimination and have it dealt with. We are seeing evidence of that happening.

Senator TCHEN—You do not subscribe to the Professor Higgins model of behaviour: treat all the duchesses like flower girls, and treat all the flower girls like duchesses?

Miss Meppem—They are all equal participants in this process.

Senator TCHEN—On the earlier point about what the departments are doing, clinical education is an area which you identify as being of ongoing importance. Has New South Wales Health done anything to support the provision of further clinical education?

Miss Meppem—The government provides $22 million a year in quarantined funding for nursing initiatives. That is particularly focused around education: clinical education, support of the new graduate coming into the work force, specialty skill development so that nurses can then move into our different specialty areas and mentorship programs as they move into those specialty areas.

We have a major contract with the New South Wales College of Nursing for educational programs that they run on our behalf. We provide salary supplementation to the area health services to allow them to backfill those positions when the nurse goes off to the college. We provide funding for enrolled nurse initiatives. We fund the Trainee Enrolled Nurse Program that TAFE run for us and we have a scholarship fund with in excess of $1 million in it that provides scholarships for, as I mentioned earlier, rural people undertaking their degree in nursing and also registered nurses undertaking postgraduate education in the university sector. That $22 million plus per year is over and above the area health services recurrent budget and is specifically quarantined for nursing initiatives. It cannot be used for anything else.

Senator TCHEN—In the attachment on tertiary nursing education issues on page 6 you say, with respect to the redistribution of nursing education amongst the institutions, that the effect is unclear at this stage. However you suggest that the Commonwealth should discuss this matter. If the effect is unclear, why go ahead with it?

Miss Meppem—That is in relation to the undergraduate program in particular. It relates to when the transfer of nursing education took place and the New South Wales government moved the budget to the Commonwealth who are now responsible for undergraduate nursing education. We believe that, at the time of this paper, some of our universities were having more success in

attracting students than others, but there has been no redistribution of places because that is now something we have very limited control over. Also, we agreed to the transfer on the basis the universities would continue to meet our work force needs, and certainly the enrolment numbers in our undergraduate programs are not meeting that agreed target. That is what that is referring to. We believe that perhaps there is capacity for some redistribution of student places to universities that have less trouble attracting students.

Senator TCHEN—Has New South Wales had this discussion with DEST about it?

Miss Meppem—I am sorry?

Senator TCHEN—The Department of Education, Science and Training.

Miss Meppem—We have raised it on a number of occasions with the Commonwealth.

Senator TCHEN—I have one last question and Ms Dent might want to answer as well. What is your view of a national registration system? A number of witnesses have proposed such a system.

Ms Dent—We would see that as a matter for government in the public interest. In terms of the issues being raised for this Senate inquiry, they are very broad ranging and I do not believe they could all be solved by a change of registration system.

Ms Dyer—Essentially, the board is not aware of any current system for registration which potentially would affect numbers—people coming in, people staying in the system, whether it be either central or national, or remain at state level. Certainly with educational issues the board has looked long and hard at the role of a national system just amongst ourselves and can see no real benefits in a national registration system with regard to the education of nurses. It is about setting standards for the education wherever that may occur and it certainly allows for greater flexibility where it is not necessarily a nationally governed registration system. The issues in regard to curriculum constraints and things like that are often about regulation requirements and standards rather than a national regulatory system. Essentially, regulation requirements for becoming a registered nurse in New South Wales are very similar across Australia. We have cross-accreditation, so somebody registered in New South Wales will be registered in Queensland should they simply apply for that, with mutual recognition. That works very effectively. We are unaware of delays in people gaining registration. We do not have a waiting list.

CHAIR—You are not pushing for national registration?

Ms Dyer—Correct.

Senator LEES—Senator Tchen has asked most of my questions, but I would like to go back to the exit point between university and when nurses come out and start working. I refer to point 2 in your submission, the interface between universities and the health system. You mentioned in your introductory remarks that this was an area in which you were looking to do some research. What is the time line for that research?

Miss Meppem—Because we were not successful with our PDR funding request we have been in negotiation with the other jurisdictions to see whether they want to get involved because we were going to move ahead with it. The first steering committee meeting is in two weeks time. The office of the NHMRC have agreed to manage the process for us. So I would anticipate that with no undue delays the EOI would be advertised by the end of May, hopefully, and that we would move very quickly through that selection process. The research would get underway as soon as we can possibly get it moving. It is not a short-term research project, it is a major piece of research.

Senator LEES—I take it you will be tracking students—as the universities discussed with us this morning—and that where the students come from is an issue.

Miss Meppem—No; that is not our research.

Senator LEES—Yes, but you will take some of that on board. Will you take on board any of the prehistory that students bring in with them—things like their age, their point of embarkation into nursing, and whether or not they started through an enrolled nurse program and then moved into the degree—and would that give them a better outcome in terms of succeeding when they move into the work force compared to students who have gone straight into university?

Miss Meppem—There may be elements of that in the research but it is not about the student or the preparation. Our research is primarily focused on workload: it is about skill mix, staffing levels, models of nursing care and the different configurations of those and what impact it has on patient outcome. We are looking for some rigorous information about whether more staff means better patient care and whether a different skill mix means better patient care or worse patient care. So it is about the actual workload of the nurse on the ward or in the unit.

Senator LEES—You will be looking at patient care; will you also be looking at the nurse as well?

Miss Meppem—Certainly.

Senator LEES—And whether or not he or she is actually staying around?

Miss Meppem—Certainly there will be elements of that built into the research. Clearly, we are going to have to wait and see what the researchers in Australia put forward as a way of addressing the terms of reference of the research, but I would imagine that there would be a lot of those elements built into the research itself.

Senator LEES—One of the issues for the committee that keeps coming up is not only the loss during university but also the quite large percentage that disappear after university, or who may experience the workplace briefly and then—

Miss Meppem—They move in and out.

Senator LEES—Yes. Is there a project in New South Wales that you are aware of that would monitor where those final year students go?

Miss Meppem—Individual universities, I think, track some of them, but I would imagine there would be elements of that in our research.

CHAIR—You said before that you did not have data for the number of nurses and that you would have to go to the area health board. Do you have all the data about the number of nurses and where they are disposed and so on?

Miss Meppem—Yes, we do. We have figures on an area basis of the number of nurses employed, the number of positions they are recruiting, the number of supplementary staff they are using—casual pool, agency staff—that sort of thing. We do not collect figures for our private sector work force—or we haven't. But last year the private hospital regulations were changed and as a condition of their licence we will now be collecting work force information on the private sector, so we will be able to match that with the public sector to look at the nursing work force as a whole. But, certainly, we have those figures.

CHAIR—Is that being published?

Miss Meppem—It will be.

CHAIR—At this stage you produce excellent maps on childbirth et cetera.

Miss Meppem—We publish the annual profile of the nursing work force in the public sector. We also publish the profile from the nurses registration statistics on both the public and private sector. We have a program called Nursing DOHRS, the Department of Health reporting system, which reports the sort of information about vacancies, supplementary staff in the public sector and we will be able to report on the private sector by the end of this year.

CHAIR—Are you the person everyone in New South Wales rings when they want an answer about nurses?

Miss Meppem—Yes, I think so.

CHAIR—So New South Wales does not need to get a chief nurse?

Miss Meppem—No.

CHAIR—New South Wales has one. I want to go back to the question Senator Knowles was principally asking the board. It is your requirement that nurses pass an adequate curriculum up to scratch and that you can tick them off as being okay to practise. To what extent do you look at where they practise, to satisfy yourselves that they are not being asked to practise in unfit accommodation, as in a hospital with dreadful beds or broken intravenous equipment?

Ms Dent—That is not really within the jurisdiction of the board. The ACHS would go ahead and do some accreditation.

CHAIR—ACHS?

Miss Meppem—The Australian Council on Healthcare Standards, who do the accreditation of health facilities. When they are accrediting places for clinical placement, the board would also look at those issues.

Ms Dent—We do nurse education inspections, but we look at where the enrolled nurse students and midwifery students are going. The board retains the power to inspect areas of clinical experience for undergraduate students, but it has not done so in the recent past. The difference is that undergraduate students have been supernumerary. The enrolled nurse students and midwifery students are often part of the work force and can be rostered with a priority of working, versus a priority of an educational experience. So the board has not undertaken inspections for a number of years of where preregistration students go. They do get assessed when they are in those hospitals where enrolled nurse training and midwifery training is undertaken.

CHAIR—There seems to be an interesting set of lines drawn between where your responsibility stops and where somebody else's starts. You are telling us that if they are students—so-called supernumeraries—they are not a matter for your regard, but if they are collecting a dollar or two for being there, they are?

Ms Dent—Sorry, no. The students are the responsibility of the board in terms of where they get their clinical experience, whether they are supernumerary or whether they are part of a work force in training. A number of years ago the board inspected all areas where students were going and universities were undertaking the same types of reports. The board made the decision at that time that, unless the clinical experience area was unusual, it was not a requirement for us to inspect the areas.

CHAIR—So it was your decision to withdraw from that area?

Ms Dent—The board made that decision, yes, but it retains the right to do inspections at any time.

Ms Dyer—The inspections that are done on an educational level are not about whether beds work or whether the environment is safe.

CHAIR—How can you learn, if you are a nurse, if there are appalling facilities?

Ms Dyer—I agree, but the type of review or inspection is about what kind of educational support they have and whether the unit follows a reasonable standard of practice. We would have no jurisdiction and no power to say to somebody, 'Your beds do not work.'

CHAIR—That is right, but if you were out there and you noticed that the facilities were very insufficient, presumably the board would have the capacity under its own initiative to ring—if nobody else—at least Miss Meppem and to say, 'I have seen shocking things.'

Ms Dent—That is certainly the case. The board can most definitely withdraw approval of universities and of clinical areas.

Miss Meppem—Also, under our occupational health and safety legislation in New South Wales, there are a number of other avenues for those issues to be raised with the department.

CHAIR—If there is no home or house for a nurse in far western New South Wales, is that an OH&S matter, and if not, why not?

Miss Meppem—I would have to take that on notice.

CHAIR—I would not like to introduce you to a creative area of thinking, Miss Meppem, but if it was to be so, I think Senator Knowles and I would be in total agreement on this point. Forgive me for being facetious. One other area that has come up which is terribly important is information technology. You have talked about distance learning and I presume that is not by telephone. Does it include high-tech parameters?

Ms Dent—In the most recent program that came through the university had prepared case discussions on the web site and had demonstrated their case to the accreditation committee. Unfortunately, I was not on that committee so I do not actually know what the committee viewed. The committee was very impressed with the online presentations and learning experiences that students could achieve through the web site.

CHAIR—Where do they learn? What facilities for IT proficiency are there for a nursing student?

Ms Dent—It is my understanding that the universities demonstrate how they ensure that students have sufficient computer literacy and have sufficient access to computers to be able to participate in those programs.

Senator KNOWLES—The other question about technology is the question about ICU, CCU, all the monitors and everything else. How do you train nurses to be able to work all those gismos, to be proficient at doing so when they leave and to be able to keep up with the changing trends and new equipment?

Ms Dent—As part of the course they start, I suppose, from simple and go to complex. They have their theory—I am not within a university so I can only suggest that the programs demonstrate what the student will be studying in a theoretical base—they go through laboratory work and then they experience the real life practical experience in a hospital setting. Obviously, when they come out they may not be as experienced on those machines as someone who has been out for six months. So they are beginning registered nurses in that respect.

Miss Meppem—It is picked up by the health services then as part of the transition into the workforce and as part of the specialty skill development on the job with that machinery. You are quite right, keeping up with it is quite a challenge.

CHAIR—It is an interesting point. We had evidence given to us today that some places have education of that sort in the clinical setting, or at least associated with it. I think it was in the Sydney Adventist Hospital that they have a practical laboratory type situation where there is equipment and you can have a practice run on it, which is very encouraging, before you actually

go and work on it. We have also had given to us evidence that virtual reality may be a way to teach nursing.

Ms Dyer—I think that is a great idea. Certainly, I know that if we look to Western Australia—I have forgotten the proper name of this—we can see an example of where medical officers can do simulation exercises, where they can actually do suturing and do major surgery, obviously on non-human participants. That sort of area needs to be investigated, particularly for nursing and midwifery in the future, so that our students can get a chance to experience real life in the sense of—

CHAIR—Real life in virtual reality. Thank you, Ms Dyer. Can you experience real life in virtual reality?

Ms Dyer—I think you can make your heart beat faster, I think you can get anxious and I think you can absolutely get a sensation of how you may or may not cope in that scenario.

Senator KNOWLES—I think that is absolutely fantastic. It has been done in UWA; the dummies they have there are just unbelievable.

Ms Dyer—Certainly I can say that, as part of the advanced life support obstetrics program running throughout New South Wales and Australia now, even our most experience clinicians get anxious and nervous in a simulated setting. Most of them will walk away saying that they have learnt something. So, yes, as a garden variety clinician, I would absolutely support that in education.

CHAIR—Thank you very much, Ms Dyer, I am really helped by that. I wanted to go to another dimension of IT that I think is very important. We have been learning that general practice is very much coming online. We have heard that, for example, one of the challenges for community health nurses is that they are having to care in the community for people who are only one or two days post-operative. Associated with this is the opportunity through IT in hospitals to send the patient home with the summary of the in-patient treatment hopefully arriving at the relevant GP within a very short time, like a day or two. Where does the nursing profession fit into that script? Do they have access to any of those computer systems? If they do, what are the privacy implications? Is it an area that is still ahead of us?

Miss Meppem—It is certainly an area. It is not in my portfolio but I can make a general comment about the electronic health record that has been developed in New South Wales Health. Nurses are very involved in the development of that and there are some issues around privacy which are being resolved through that process.

We also have in New South Wales what is called CIAP, the Clinical Information Access Program, which is a very successful Internet based clinical information system that provides up-to-date clinical information at point of care. That has been particularly successful across New South Wales, particularly in our rural areas. That has been developed over the last four or five years and now is providing nurses, in particular, with access to immediate up-to-date clinical information on a whole variety of different clinical situations.

CHAIR—Where do they get their computers?

Miss Meppem—At the health service. Certainly there are issues around the provision of hardware and lines to make it work, particularly out in the far west. But there is a lot of effort going on in our information division at the department to get that widely spread throughout New South Wales Health.

CHAIR—I can imagine this would be something easier to manage within the hospital setting than if you were a community health nurse trying to go and visit Mr Bloggs.

Miss Meppem—We have the palm pilot.

CHAIR—You have a palm pilot. It is as easy as that, is it, Miss Meppem?

Miss Meppem—So they tell me.

Ms Dyer—I would like to make a comment. That is something very dear to my heart as a clinician. Essentially, as nurses we need to be involved in the development of things like point of care. At the moment most point-of-care systems are minus good clinical input. I think it is an imperative part of it. If it is going to work for nurses, nurses need to do it. That has been one of the issues with all of our opportunities to use web based technology.

CHAIR—It would be interesting, Miss Meppem. Who would know better than you—and I do not mean that in any disparaging way, I am just not sure whom I should ask about this. The nursing unions might be able to help us. What is the state of play for computer data for nurses? If you see a patient out in the community and you zap it into your palm pilot it will go where? Is that network of computer files of the nurses parallel to, or related to, the general practitioner? I am interested in how the two are connected.

Miss Meppem—It is my understanding that when the electronic record is up and running across New South Wales everybody will be interfaced into that. I could get you some more information on that if you would like.

CHAIR—I would appreciate that. Over the last few years the Commonwealth government has assisted general practitioners to become technology literate by suggesting that, if they apply, they will be eligible for $3,000 each to assist them with the cost of a computer. Are you aware of this program being available to nurses?

Miss Meppem—Through our area health services the hardware and software are provided by the area health service, not to individual practitioners.

CHAIR—So what happens if you are down the road? Do they give you a palm pilot?

Miss Meppem—That is where I think we are going. Certainly that is the sort of information I can get you about what is planned. It is password protected.

CHAIR—Any evidence about whether the Commonwealth government is funding hardware, let alone software, for the nursing profession would be interesting too. Senator Lees wanted a last question.

Senator LEES—To carry on from where I looked at it in another jurisdiction, the hospital discharges people very early now so the community nurse picks up. They sometimes have a difficult lag time in getting what they need by way of what the patient needs. Once the community nurse has got the bandages off or the stitches out, the GP on their computer basically needs the same set of information. Is this where we are going?

Miss Meppem—I understand that is where we are going.

CHAIR—I have a last question regarding nurse practitioners in New South Wales. It is probably for you, Miss Meppem, but maybe for both of you. Can you outline the operation and training: how and where—in three seconds, of course—the impact in rural and remote areas and how this is fitting in with other practitioners, particularly the medical practitioners? What have you been doing to sort this out? Who has been talking to whom under whose guidance?

Miss Meppem—I will leave the issue about authorisation to the board. The nurse practitioner project is moving slowly in New South Wales. We have four positions approved, all out in the far west. We have only have one nurse practitioner practising in one of those positions, because nobody wants to go out and work in those particular towns at the moment. We have eight other nurse practitioners authorised by the board, so that is nine in total. Thirteen other positions have been approved in principle, and they are now having their clinical guidelines developed. There are a number of other positions in development.

We have funded two programs at the New South Wales College of Nursing to assist potential nurse practitioners prepare for the authorisation process. We have put in an independent review of the clinical guidelines as another step to assure everybody that the guidelines that have been developed are appropriate for that practice context. We are just about to move into the development of some generic guidelines to try to help the process move a little bit faster. There is continued opposition from some aspects of the medical profession; we are working very hard on an issue basis to resolve those, but certainly there is still some concern being expressed there.

CHAIR—I ask, on notice, what a nurse practitioner would earn, particularly as compared to a nurse comparably equivalent.

Miss Meppem—There is an award classification that has been struck for nurse practitioners. My colleagues could probably answer that question immediately in their session. It is at the equivalent level to a clinical nurse consultant; it is seen as being at that senior clinical level, but that also provides the capacity for them to earn shift penalties as well if they work after-hours.

CHAIR—If you go far west, do you get a living away from home allowance?

Miss Meppem—No.

CHAIR—You don't even get a house. Gosh, you're hard. What is the accreditation, Ms Dent?

Ms Dent—The authorisation process involves two stages. It was recommended to the board by a steering committee set up for that purpose: to look at the assessment process and the

criteria for authorisation. The first stage is that the applicant has to put in a portfolio to demonstrate their knowledge base. That goes across health assessment, diagnosis, therapeutic management and the evaluation of their care. The second stage is a clinical viva, in which they have to demonstrate their knowledge base in a particular scenario. There is an authorisation assessment committee set up by the board, and that committee makes a full report to the board and makes recommendations regarding the authorisation of nurse practitioners. The award classification is $1,286 per week.

Senator KNOWLES—Does New South Wales have any indemnity cover for off duty nurses who assist in MVAs or anything like that, or is their assistance putting them at risk of future litigation?

Miss Meppem—If they assist as a private citizen?

Senator KNOWLES—If they assist as a private citizen, off duty nurse.

Miss Meppem—No, they are covered when they are employed and working at their place of employment.

Senator KNOWLES—So if they come across an MVA, for example, and someone thinks they have done the wrong thing instead of driving by—

Miss Meppem—If they stop in their capacity as a private citizen, no.

CHAIR—What training is provided for the nurse practitioner and where do they get it?

Ms Dent—Currently, there are two mechanisms by which a person can be authorised. A number of universities have developed courses for nurse practitioners, and the board has approved those courses. They are at master's level. Alternatively, there is the other process, which enables a person who is a registered nurse with advanced nursing practice experience and knowledge to apply to the board through the portfolio and clinical viva process.

CHAIR—Miss Meppem, we have been told on a number of occasions that, particularly in the aged care area—and I do not know to what extent this is your jurisdiction, so forgive me—a lot of challenges occur about who can give medication. I understand that enrolled nurses in New South Wales are not eligible to administer schedule 4 or more medications. RNs can; ENs cannot, but the law does not say anything about AINs—or the unqualified people—who in fact do administer medication. Is this the situation?

Miss Meppem—The public sector enrolled nurses are able to give a range of medications up to schedule 4 if they have done a program. That was part of our enrolled nurse review that was held in 1991. I know there are issues in the aged care sector. That is not my portfolio; it is monitored by our private sector branch. Certainly, the issue of the administration of medications is an issue that we are currently looking at within the department on a statewide basis with regard to public safety, et cetera.

CHAIR—I cannot ask you what you might be advising your minister, but is it possible for you to answer whether there is a consideration to amend the legislation so as to make it clear that if ENs cannot, anybody less qualified than an EN cannot too?

Miss Meppem—I cannot answer that question about whether there is an intention, but I certainly think those issues will be raised in the review that we are going to undertake.

CHAIR—We have passed our time again. Thank you very much indeed. If there is anything more that strikes us, I presume we can contact you—and, likewise, in reverse.

Miss Meppem—Certainly. Thank you.

[3.06 p.m.]

HOLMES, Mr Brett, Assistant General Secretary, New South Wales Nurses Association

McDONALD, Mrs Tracey, Manager, Professional Services, New South Wales Nurses Association

CHAIR—Welcome. The committee prefers all evidence to be given in public but, if you want to give any evidence in camera, you can ask to do so and the committee will give consideration to your request. I must remind you that evidence given to the committee is protected by parliamentary privilege and that, should you give us any false or misleading evidence, it could constitute a contempt of the Senate. I do not expect that that is your intention. The committee has before it your submission No. 899. Do you wish to make any amendments or changes to that submission?

Mr Holmes—Not at this point.

CHAIR—Please make a brief opening statement and then field questions.

Mr Holmes—I will be brief, thank you, Senator—acknowledging the time constraints that you have. Thank you for the opportunity to speak to the committee. The Nurses Association is an industrial and professional organisation here in New South Wales, with a membership of 47,700 members financial at this point in time. We represent, as I said, both the industrial and the professional issues for nurses right across the spectrum of nursing. We provide union coverage for members working anywhere in New South Wales and having the job title of nurse. That means in the public health system, the private health system, aged care, occupational health and safety nurses—the whole range of nurses who work here in New South Wales.

Our issues in terms of nursing certainly revolve around some of our principal responsibilities as a trade union for nurses, but they are intertwined with the professional issues that nurses face. The New South Wales Nurses Association has, over the years, prided itself on trying to maintain relativities between nurses who work in the public health system, those in the private health system and those in the aged care system as well: that is, relativities in pay structures and, as much as possible, in the conditions that they work under.

We face in all areas of the profession—as you are hearing—on a day-to-day basis, a critical shortage. That critical shortage, we believe, has quite a number of facets. One of those facets is, obviously, how nurses feel about their job: whether they achieve job satisfaction on a daily basis; whether they feel that they are valued in their work; and whether the work that they are doing allows them to live a reasonable life, in line with the expectations that the rest of the community has. Right at this moment, our impression from our membership is that nurses do not feel well valued by the community. It is one thing to be regarded in a popularity poll as being at the high end of the spectrum—at the top in terms of being respected, in fact—but you also have to put alongside that how you are financially rewarded and how you are valued within the workplace. Nurses report to us that they do not feel that they are financially rewarded for the level of responsibility that they are currently undertaking.

One of the areas that provide us with the most difficulty in the field of remuneration is certainly the area of aged care. New South Wales is much more fortunate than other states in that we have maintained that relativity which I talked about earlier between public and aged care. The difference is that, right at the moment, our aged care nurses are being paid five per cent less than the public sector nurses. We have at this point in time a 15 per cent pay claim that will be going to a special case hearing in the New South Wales Industrial Relations Commission, starting in June of this year.

What we fear is that aged care nurses will be left behind in the pay relativity issue, as they have been in other states of Australia. It is a deplorable situation that we have a federal government that funds the aged care system but fails to recognise that one of the major costs of aged care is the nursing work force. It is about providing nursing to very frail, very ill residents in nursing homes. Those frail, ill, dependent people require and deserve the same high level of skills and experience that nurses should be able to provide to the acute care sector. But what we see in other states and what we fear could appear here in New South Wales is a very significant financial differentiation between aged care sector and public sector—in some states as much as a 20 per cent pay differential. That can only lead to a deterioration in the aged care sector in terms of its ability to compete in a very small, diminishing market for a nursing work force. So we have major concerns here in New South Wales that, whilst we have to value nurses in the public sector, the aged care sector is saying very clearly to us that there is insufficient funding going to the aged care sector in order to pay nurses similar rates to those paid in the public sector.

We intend to do everything within our power as an industrial organisation to try and improve that situation. But we are no doubt dependent on the fact that funding for aged care comes from the federal government. It is a significant issue that there is a high level of disappointment and frustration from many nurses who work in the aged care sector, about that differential. They feel that they are sometimes second class nurses, and that is not the case. Let me say very clearly that to work in an aged care facility you have to be able to look at people who are chronically ill, who have multisystem failure. They are not simply there because they cannot walk. To be classified for aged care, they must have a multisystem failure. They need expert nursing care. But we have a situation where there are relatively small numbers of registered nurses and a larger number of unlicensed workers in our state—assistants in nursing, and other care workers called personal care assistants or care service employees—who perform work, hopefully, under the guidance and supervision of a registered nurse.

I will conclude my remarks by saying that the issue of the nursing shortage has to be dealt with by a range of approaches. Our role is obviously to work on the industrial issues and the professional issues. We have taken action here in New South Wales to try and address the issue of nurses' wages. We will have to do that via a special case in the New South Wales jurisdiction and we will be putting substantial evidence which will inform the commission—and, hopefully, the New South Wales government—of the increased value that nurses have added to the New South Wales health system.

CHAIR—I am sorry to stop you, Mr Holmes, but you appreciate, as you indicated in your opening remarks, that we are squashed for time, and so we are trying to hear from as many witnesses as we can. If there is something at the end that you absolutely want to put on the

record but that no-one has asked you a question about, can you make sure that you give me the call and we will get that on the record.

Mr Holmes—Yes.

CHAIR—Do you wish to add anything at this time, Mrs McDonald?

Mrs McDonald—I will reserve until the end of questions.

CHAIR—Thank you very much. Senator Knowles has a question.

Senator KNOWLES—Could I just clarify this with you? I think you mentioned it but I missed it. What is the wage structure for nurses out of aged care, for nurses in New South Wales vis-a-vis the other states?

Mr Holmes—New South Wales compares very well with other states. We can provide to the committee our rates of pay. But, in terms of a comparison with Victoria, there is a very small difference currently between New South Wales registered nurse rates and Victorian rates.

Senator KNOWLES—Which way?

Mr Holmes—Ours are under by a small $6 to $10 per week. That will be overtaken in January of next year, when nurses in the New South Wales public system will receive another four per cent increase. We are currently in a wages deal which spreads 16 per cent over 4½ years.

Senator KNOWLES—Has that led to any industrial disputation in recent times?

Mr Holmes—We have had industrial disputation about our special case application, which involved one day of a 14-hour stop work, where nurses supplied services on a 'critical situation only' basis in October of last year. Apart from that, there have been relatively small disruptions to the service. Nurses at all times, as you know, are cognisant of the fact that we need to provide care, but we also have to demonstrate clearly both to the public and to government the high level of distress that our membership feels.

Senator KNOWLES—I, like you, believe that aged care nurses are an exceptionally special breed of people. What would be your reaction if, for example, aged care nurses were to get their pay increase—say, even just the five per cent to bring them up to other nurses? What would be the reaction of your organisation to that? Would you then try and push the others up to stay ahead of them? Or would you say, 'At last now we are on the same level'?

Mr Holmes—The New South Wales Nurses Association philosophy is that nurses, whether they work in aged care or acute care, public or private, are of equal value. So it is not a matter of leapfrogging one another; it is a matter of, in most cases, the acute public sector setting the standard which we try to come alongside—and we are successful in large part in the private health hospital sector, but less successful at this point in time in the aged care sector. So it is not a matter of five per cent going to aged care; the reality is that there is an additional four and five

per cent to come in the already agreed agreement, and obviously we are of the philosophical opinion that nurses should be paid equally.

Senator KNOWLES—So you would not see any cause for concern that, if one was bumped up, the other one would want to bump up and it would just cause a stepladder effect.

Mr Holmes—No, we do not put that situation in place where one sector is of higher value than another. We believe that the aged care sector is of equal value to the acute care sector as is the private hospital system. Where private employers decide that they want to pay more, we are more than happy for them to use market forces to try and fill their vacancies.

Senator KNOWLES—In your submission you stereotype nurses as 'angels of mercy'. In your oral submission you also said that you shared the concern that the work of nurses was undervalued in the community and in the workplace. How would you see a collaborative approach of being able to say, 'This is just not satisfactory; these people should be valued, are valued'? And, therefore, you would get that spin-off effect for younger people. When they think of nursing as a profession, they will view it as a valuable profession. Having heard from four states, we have the impression that the nurses themselves, when they are qualified, really feel undervalued—and that is spinning back the wrong way. So those who are thinking about going into it are almost talked out of it by those who are in it.

Mr Holmes—That is right.

Mrs McDonald—That is unfortunately true.

Mr Holmes—On that point, it is one of my biggest disappointments to go to meetings of nurses and have called out to me that nurses there would never let their children become nurses. I find that, as a nurse, very distressing, but it is a fact that I am faced with, at meeting after meeting, when I am talking to members. That is a very sorry tale to tell.

Senator KNOWLES—How do we reverse it?

Mr Holmes—I think we have to reverse it by looking at how nurses are valued. I believe that nurses need to be financially valued. They also need to be recognised in the workplace as being valued. Their skills, experience and ability to manage need to be recognised as well.

Senator KNOWLES—Are you are saying to me that management in public or private sectors do not reinforce with their staff their value?

Mr Holmes—I believe that is commonly the case.

Mrs McDonald—If you think about what the indicators are of an employee who is valued and if you start applying that to the way nurses are managed, you will come up with a bit of insight into what it is that drives your normal employed person. One of them is that you need to be able to have stability in your position. There is a high casualisation rate in nursing. A lot of this is driven by budget bottom lines, for all sorts of reasons. As a working person, you also need to have some sense that you are actually contributing a worthwhile service to the community. When nurses go to work, because there are so few of them and because there is a

shortage of doctors and services are so stretched, they are abused, blamed and treated quite poorly by the general community and by managers because they are at the front line. So the feeling that they are providing a worthwhile service is sometimes difficult to achieve.

If you look at the normal working person in terms of their family, 93 per cent of nurses are women and around 70 per cent of them are family women. So you are looking at a group of people who really do require some other consideration in terms of a dual responsibility life. You have people with children at school. Older nurses are looking after their parents. It seems that one of those wonderful things about being a nurse is that they end up being the person who takes on the care of the elderly relatives.

They move from a period where they are looking after the young family to a period where they are looking after the older members of the family. In the meantime, they are trying to carry a clinical load, take on management responsibilities, self-improve, et cetera. There is very little that supports that. A lot of the systems that are in place have been geared around the uncomplicated employee who does not have these dual responsibilities. There is the child-care aspect and even the shift work aspect, where nurses have to park in areas that are well away from the hospital, across two paddocks where there are no lights. They have to park there because they are nurses; other people get parking right under the lights near the building.

Senator KNOWLES—I am looking for solutions. I think we have now identified the problems repeatedly. What I am looking for from people like your good selves is a solution. How do we solve it? How do we get that culture shift from management to a different attitude to staff to enhance their belief of wellbeing and value? And how do we overcome the bullying that has been so commonly talked about?

Mr Holmes—One of the issues that has an impact up and down the line, whether it be the nurse at the work face, the nursing unit manager who runs the ward, the nurse administrator or the director of nursing, is the change to medical technology and the changes in medicine. We have seen increased workload for nurses where you have higher acuity and throughput—

CHAIR—You are not going to take that away, though, are you?

Mr Holmes—We may not take it away but what we have to do is look at whether there are enough nurses there to do the job, because in previous years, prior to some of the increases in acuity and increased throughput, our health system has become fairly productive. Its productivity over the last few years has improved. That pressure then comes onto nurses and the nurses have to manage in the budget. Pressure goes from top to bottom and bottom to top in terms of nurses on the floor saying, 'We need more help,' the nurse in the middle saying, 'I can't get you more help, I've got a budget problem,' and the nurse at the top trying to manage the budget saying, 'No more; we can't supply any more nurses because of the budget.'

CHAIR—How are we going to solve it? Are you going to ask for more nurses?

Mr Holmes—Yes. We believe that workload measures need to be put in place to identify just how many nurses are needed.

CHAIR—This is part of the research that we just heard about from the chief nurse?

Mr Holmes—We have great expectations that that research will come up with some assistance in that area.

Senator KNOWLES—Are we talking about the nurse to patient ratio?

Mr Holmes—It may be more sophisticated or just as basic as a nurse to patient ratio.

Mrs McDonald—We are hoping that it is going to be more sophisticated, because a nurse is not a nurse is not a nurse. There are differences.

Senator KNOWLES—And a patient is not a patient.

Mrs McDonald—Exactly, yes.

CHAIR—But you and others have said to us that one of the things that really helps—and this is further to Senator Knowles's question—is education. If the nurses feel sufficiently competent and confident in their own ability and/or if they find there is a preceptor or somebody there who has the time to answer their question 'Am I doing it right?' or to keep an eye on them, this also is a way you can change that culture in the workplace.

Mrs McDonald—A lot of stress is put on people already in the work force, to the point where there is a growing feeling amongst the nurses I speak with that there is underemployment of nurses, that the shortage has been the best excuse in the world to cut down on the number of positions you are funding because of the vacancies, so the funding gets removed. There is an underemployment now that is leading to greater pressure on the people who are employed. If you ask these people to then take on supervision of students, supervision of new graduates, mentoring, preceptorships et cetera, that adds unbelievable work pressure on people who are carrying a clinical load as well as managing the environment it is occurring in.

CHAIR—I was not suggesting that it should be all the one person.

Mrs McDonald—The infrastructure has been whittled away in New South Wales over many years. The nurse educator infrastructure is now down to bare bones. There is no access to somebody who has the time to coach or to mentor, any of the new skills, new technologies et cetera.

CHAIR—What about the other point we have had raised with us, and that is that for nurses there is no financial recognition when they get postgraduate qualifications? Is it something you are campaigning for?

Mr Holmes—That is right. It is part of our special case application to the New South Wales Industrial Relations Commission to provide qualification allowances for nurses and for nurses to be paid a weekly allowance for the highest qualification they hold. It is similar to the qualification allowance agreed to in Victoria some 12 months ago. It is a turn from the 1990s when the introduction of professional rates saw the removal of certificate allowances. Before that time, many nurses—similar to me—had a range of certificates and were paid on the basis of those certificates, in addition to the base rate. We have seen the need to compensate nurses who have to pay the full postgraduate course fees to go to university to be a specialist nurse. It is the pub-

lic who are missing out because there is a shortage of specialist nurses. The fact that nurses pay that full fee to be able to provide a specialist nursing service has certainly had an impact on the quality of health care that is being given.

Senator LEES—Are you trialling different shifts, four-hour to 12-hour shifts?

Mr Holmes—We have 12-hour pilot shift programs in both the public acute sector and the private hospital sector. There are opportunities within private hospital award and the aged care sector where people can have breaks in their shift, which goes to people working to suit their needs in before and after school care situations. Hospitals are not restricted from employing people on shorter shifts than the traditional eight-hour shift. So there is the opportunity to employ up to 12 hours and for shorter periods.

Senator LEES—My other question relates to an earlier comment you made about unqualified nurse attendants—they seem to have different names in different states.

Mr Holmes—In New South Wales they are called assistants in nursing.

Senator LEES—I understood that they are supposed to have a formal certificate qualification ,which is being phased in?

Mrs McDonald—Yes. There is an agreement under the Australian Qualifications Framework that anyone providing direct care—this is mainly in the aged care sector—is preferred to have a certificate III as the minimum. Unfortunately, the way it is set up, in order to access the certificate III, you have to have three months experience in the workplace. So it is a chicken and egg situation. The majority of people who are employed in the aged care sector do not have a certificate III.

Senator LEES—The majority?

Mrs McDonald—Yes.

Mr Holmes—There are many thousands of assistants in nursing here in New South Wales. To do that course, not only do they have to have that experience but also they have to do that training in their own time. We are talking about people who are bringing home $440 to $450 a week. They are struggling on that, yet they do at least half of their additional training in their own time.

Mrs McDonald—The certificate III is very basic. It does not give you anything beyond the basic fundamentals of survival in the work environment. Yet, as was mentioned in the earlier interview, there are people at this level, and without qualifications, being asked to give medication, including injections, and make judgment calls about pain medication which is under a schedule. In November, last year, the legislation was changed, simply because of the shortage of registered nurses, to allow these people to do this with impunity.

CHAIR—What is a certificate II nurse, if what you have said is a certificate III?

Mrs McDonald—A certificate II is equivalent to a kitchen hand or a trolley person who moves equipment around for somebody who is directing them.

Senator TCHEN—Does your association cover certificate II and certificate III nurses as well—if they are called nurses?

Mr Holmes—We cover assistants in nursing, those that have the certificate 3 and those who do not, so they are within our nursing family here in New South Wales and are provided with coverage. It is not the same in every state.

Senator TCHEN—That was a curiosity question. The real question is: on page 2 of your submission you refer to a recent New South Wales survey of 10,000 nurses who are not currently working and you footnote it as No. 1, but I cannot find the footnote anywhere. Can you tell me which survey it was?

Mrs McDonald—It is the survey that Judith Meppem, Chief Nurse of New South Wales, commissioned.

Senator TCHEN—It is not listed here, either. Although the sample is probably not typical because they are nurses who are not at work at the moment, that is a very respectable 10,000 nurses. I was curious to see that the No.1 incentive is flexible working hours.

Mrs McDonald—That is true.

Senator TCHEN—It seems to me that is what agency nursing offers as well.

Mrs McDonald—One of the reactions to the dual responsibilities that many nurses face is that you need to have some flexibility and control over the hours you work. When you work in environments where that flexibility is not available and you are on a set roster and the people that have the shifts that you want are not prepared to swap with you, then the only other option you have is to move out and become an agency nurse where you can choose your hours—you can work when you want, where you want, and not work when you do not want to work. It is okay for the person doing that but the people who stay on permanently find that the most desirable shifts are the ones the agency nurses want. Therefore the agency nurses have first call on the most desirable shifts. So the permanent people who are maintaining the system end up working the less lucrative, less desirable shifts in terms of work and penalties.

Senator TCHEN—Nevertheless, if we are to bring these people back into the workforce that is the No. 1 thing you have to look at.

Mrs McDonald—Yes.

Senator TCHEN—A number of people have said to us that one of the biggest bugbears for nurses these days, particularly nurses at senior levels, is the amount of documentation, particularly in aged care. Yet management and work process changes are relatively low as an incentive to bring people back. In other words, the reverse is that those are less of a reason to drive them out in the first place. Can you comment on that?

Mrs McDonald—This study looked at a range of nurses, particularly from the public hospital sector. The documentation issues in aged care are absolutely critical, as are management practices. We submitted one of our surveys subsequently, showing that management practices and attitudes towards nurses in terms of flexibility and trying to work with them in terms of their dual responsibilities were a major contributor to their discontent. So I think it is context driven.

Senator TCHEN—Yes, and yet in a survey like this it does not quite show up. I am curious because it shows there are statistics and statistics, doesn't it? With respect to the issue about changing the traditional responsibilities between RNs, ENs and the personal carers, what is the association's view on that? If you shift those boundaries, then you can shift the work load a bit.

Mrs McDonald—We have been working on some of the federal working parties looking at the role of the enrolled nurse. We have been very keen to see the enrolled nurse scope of practice increased responsibly to a point where they could administer medications. Our difficulty is that the attitude of many of the employers, particularly in aged care, is that if you can have an enrolled nurse who can extend their scope to give medications then you do not need a registered nurse around. In order to prevent that, we need to do a lot of work about the value of having somebody who is capable of clinical assessment and clear judgment about treatment and support and protection and caring needs for people.

Enrolled nurses have a fundamental understanding of this, but they do not have that skill. So we are on the horns of a dilemma here, where we really do want the enrolled nurse scope of practice to include that, if it is responsibly done—that means, that they are educated and trained to do that competently—but at the same time we do not want to see one group viewed as a cheap replacement for another group of nurses who are highly qualified and who are essential in that context.

Senator TCHEN—That is a concern that we well understand.

CHAIR—Can you tell us anything about the percentage of agency nurses used in this area, that area or the other? Do you have access to those figures?

Mr Holmes—On their web site, the NSW Health Department publishes the nursing vacancies that are being actively recruited for, the use of casual nurses and the use of agency nurses. I apologise that I do not have those current figures in front of me, but there are currently at least 1,800 full-time equivalent positions being advertised in the NSW public health system. They are being replaced by nearly 2,000 full-time equivalent nurses who work either as part of a casual pool or as an agency nurse. So I would refer you to that web site, which is updated by Ms Meppam's team on a monthly basis. That gives a very strong picture of what is actually happening out there.

CHAIR—Can you tell us the difference between the agency rate and the going rate for ENs in aged care or for RNs in aged care?

Mr Holmes—No, I cannot. Agencies are required to pay the award minimum, but it is our understanding that they are paying different rates and charging different amounts per agency.

That is an arrangement between them and the employer, and we are not part of that arrangement.

CHAIR—Do you cover those nurses?

Mr Holmes—We provide coverage to anyone in NSW who calls themself a nurse, so an agency nurse is more than welcome to be our member, and there are many on our books. They are difficult people to come across in the workplace, though; they are often not part of the regular nursing staff and therefore do not come to our normal meetings. They subscribe to our membership and they receive the *Lamp* and that sort of thing, but we do not have frequent contact.

CHAIR—In Western Australia we heard of nurses going for a week or two-week bloc to Victoria because they could earn huge money. The fee the agency was charging was between $200 and $250 per hour, of which the agency got 55 per cent—which is easy money for the agency. As I understand it, the Victorian government has said there will be no more of that in the public hospital arena, expecting to save $20 million. I would be interested in what you would like to do with $20 million if the New South Wales government had it to hand and your organisation could bid for it.

Mr Holmes—We would certainly ask the New South Wales government to spend that in a number of ways. It is not enough to provide a pay increase for all nurses in the public health system, but it would certainly go some way towards that. Otherwise, it could be used to employ additional nurses to relieve the workload. We believe that, whilst nurses need a significant increase in wages, we will not be able to relieve the workload until there is some incentive for nurses to come back. Nevertheless, more money needs to be put in by government. Whether that comes via the health care agreements to the states or whether it has to come out of the state budgets, there need to be more nurses at the bedside. To do that, you need a bigger budget.

Senator LEES—So we need more nurses in order to get more nurses?

Mr Holmes—That is right. A lot of the reasons people leave nursing are that they cannot stand the constant workload that they are being put under.

CHAIR—I think it was Mrs McDonald who was saying before that at the moment the agency nurses get to pick their preferred rosters and that means that the poor regulars apparently come in second. I am not at all sure why. It must be a curious management which says, 'We've got some passing casuals who we'll give more preference to than you poor faithfuls.' It would seem that that is an absolutely guaranteed way in which you could insist that the nursing standards would drop—or at least the dissatisfaction in the profession and the practice would drop.

Mrs McDonald—And the fragmentation of the nursing profession itself, because you are competitive within that.

CHAIR—Have you put a submission to the government that they should ban the use of agency nurses?

Mr Holmes—We do not believe that that would be possible. Here in New South Wales the shortage is critical and any attempt by us to try and stop the government from using agency nurses would have a negative impact on our members because they would be left without that agency nurse there at the bedside to assist them. It is difficult enough at the moment to even find the agency nurse. And that is what Mrs McDonald referred to: the agency nurses pick and choose. But that also leaves many hospitals simply pushing the extra workload on the permanent staff because there is no-one there to fill the gap.

CHAIR—But if the agency nurses were not available through agencies they might, if they wanted to go nurse, apply for jobs differently.

Mrs McDonald—It is not quite as cut and dried as that.

CHAIR—I suspect not.

Mrs McDonald—If you have a permanent part-time person they may do three or four agency days as well as their permanent part-time job. You might also have people who actually have two jobs, particularly in aged care, where the Commonwealth will fund only a certain amount of hours per shift. Someone will turn up for a shift at seven o'clock thinking they are going to work till three and get told at 11 that they are no longer required.

CHAIR—One of the things that we have been told is that a lot of nurses leave in their first year. You have also highlighted another area where we are told that the opportunity for promotion has been restricted, that the advancement opportunities are just not as readily available. That is another pressure. But what happens is that a lot of nurses are leaving in their first year out because they may be an RN but they find themselves being asked to take charge almost or to be in a supervisory role over more senior nurses who are casual through agencies, or part-timers. This is a pressure on your junior RN. Have you actually taken a case to the Industrial Commission on something of that sort—that is, the work practices being inelegant?

Mr Holmes—No, we have not. It is a matter that we raise at the ministerial nursing standing committee and it is a matter of constant discussion between us, the chief nursing officer and at times the minister, raising our concerns about that very situation which is brought to us by our members, unfortunately, on a frequent basis. In terms of the award and whether we have a case to run in the commission, the employer has the duty and obligation to decide who will be the in-charge-of-shift. It is certainly clear that it could create an occupational health and safety problem for both patients and staff.

CHAIR—The occupational health and safety in terms of bullying is interesting. Do you know of any institution that has been sued by a nurse, for example because they have been bullied, through either horizontal violence—fantastic concept, that—or any other? Do you know of any nurses who have actually taken a case to their employer for failing to give them adequate protection? And is it something that should be considered?

Mr Holmes—I am not aware of any civil case in terms of the occupational health and safety legislation. I am also not aware of any nurse who has pursued that to the point of a judgment being given. It is a frequent problem; the statistics are disgusting. We have recently signed a memorandum of agreement between the health unions and the health department and each area

health service—a statement on bullying—to send a very strong message to the work force that it is unacceptable, and we try at every instance that it occurs to support the people who bring it forward.

It is a very difficult problem, a problem that nurses do not like to talk publicly about because, again, it does nothing for our recruitment strategies. It is a real problem that has been discussed internally in the nursing profession for many years without a real outcome. I believe a lot of it comes down to workplace pressure and the expectations that are put on people to perform. Some people transfer that stress onto others.

CHAIR—I have certainly learnt much during this inquiry, including a vast new way of understanding lots of language. The concept of horizontal violence still entertains me. What do you do when the one union has to represent the perpetrator and the victim?

Mr Holmes—We do that by providing separate representation. Separate officers attend for those people. If it is at the workplace level, our branch officers would do the same thing in providing separate representation. Our role in assisting anyone who is the alleged perpetrator is to ensure that they have a fair hearing and that natural justice occurs. Our role in supporting someone who has been the subject of such activity is to ensure that management takes a positive approach that will stop the bullying and that does not ultimately lead to the person who has made the allegation ending up in a worse situation. The fact is that sometimes they are the ones who are moved. Whilst there is a lot of talk about horizontal violence, I do not think we can ignore the fact that there is vertical violence as well.

Mrs McDonald—It is our experience that it is more vertical than horizontal.

CHAIR—And vertical means?

Mr Holmes—Hierarchical. It occurs as well between management and employee. Sometimes it works the other way: between an employee and their next manager. It is possible for it to work both ways.

CHAIR—We have learnt this new expression too: nurses eat their young.

Mrs McDonald—I would appreciate it if you would forget that.

CHAIR—Because?

Mrs McDonald—Because I do not think it is true, and I do not think it does anyone any good to think about nurses in that way. I think nurses are hardworking, very concerned people who really try to get the job done. As Brett was saying, sometimes you get a lot of pressure put on you and sometimes you are not as courteous as you possibly could be. To somebody who does not know what is actually going on, sometimes it can seem abrupt. But that is not what violence is, that is not what bullying is, so I really do not subscribe to that.

CHAIR—Thank you. We must finish there.

Senator TCHEN—Can I put a question to Mr Holmes on notice?

CHAIR—Yes, very quickly.

Senator TCHEN—It just occurrs to me, Mr Holmes, if both parties are members of your association, doesn't the union have some sort of responsibility in changing the culture?

CHAIR—Mr Holmes, could you respond to that question on paper.

Mr Holmes—Yes.

CHAIR—Do you have some information for us?

Mrs McDonald—Yes. We have brought with us all the awards and the pay rates for your information and also the most recent survey on what nurses think about aged care.

CHAIR—Thank you very much.

[3.55 p.m.]

FERGUSON, Dr Lorraine June, Director, Education Services, New South Wales College of Nursing

LUMBY, Professor Judy, Executive Director, New South Wales College of Nursing

OSMOND, Mrs Tracey Lee, Associate Director, Education Services, New South Wales College of Nursing

BRANS, Ms Lexie Anne, Manager, Education and Ethics, Royal College of Nursing, Australia

DAKIN, Ms Stephanie Martha Anne, Policy Officer, Royal College of Nursing, Australia

FOLEY, Mrs Elizabeth Ruth, Director, Nursing Policy and Strategic Directions, Royal College of Nursing, Australia

CHAIR—I welcome representatives of the Royal College of Nursing, Australia and the New South Wales College of Nursing. I think the Royal College of Nursing has done a bit of falling over backwards to accommodate us so we want to put our appreciation on the public record. The committee prefers all evidence to be given in public but if you want to give evidence in camera you could ask to do so and the committee would give consideration to your request. I am advised I must remind you that the evidence to the committee is protected by parliamentary privilege and, should you give any false or misleading evidence, it could constitute a contempt of the Senate. I do not understand you are here to be contemptible of the Senate. The committee has before it your submissions numbered 927 and 480. Do you wish to make any alterations to those submissions? No? I would ask each group make an opening statement and then field questions. I again apologise for a bit of a late start. Perhaps we could have the Royal College of Nursing first.

Mrs Foley—The Royal College of Nursing, Australia is the leading professional organisation for nurses in Australia. The college has approximately 10,000 members from across the country and our mission is to benefit the health of the community through promotion and recognition of professional excellence in nursing. The RCNA participates in the national nursing organisation meetings, and Rosemary Bryant, executive director of the college, appeared before the Senate committee last month as a representative of the NNOs. The college supports the NNO recommendations but wishes to bring to the committee's attention the distinction between the two ways the college is participating in the Senate inquiry into nursing.

The college would like to highlight and expand on the following arguments and recommendations from our original submission. The situation in which nursing finds itself today can, on the one hand, be explained very simply. Those who enter nursing do so for the same reasons they always have: to work with people and provide quality care. The main reason nurses leave nursing—and the profession is experiencing widespread shortages—is because they no longer feel they are able to do so.

On the other hand, explaining the shortage can get complicated as its causes involve a variety of social, political and economic changes which we have outlined in our submission. Collectively these changes have had an impact on nursing in a variety of ways but of most relevance and concern is that nurses, by and large, feel they do not have the authority and autonomy to make clinical decisions and generally take control of their working lives.

The college has been lobbying for the following strategic measures to help address the nursing shortage: firstly, trialing an Australian adapted version of the USA's highly successful Magnet Hospital Recognition Program. The aim of the Magnet program is to evaluate nursing services within health facilities with a focus on attracting and retaining qualified staff and improving health outcomes. In Magnet institutions emphasis is placed on a management philosophy in which valuing nursing is seen as central, as is adherence to standards for improving quality of patient care. Magnet facilities demonstrate a centralised structure with nurses actively involved in executive decision making. They also have flexible working practices, accountability and autonomy for nurses, continuing professional education opportunities for nurses, and adequate staffing.

Considerable research conducted overseas has shown clearly that Magnet hospitals report positive outcomes for the nursing profession and consumers of health care: in particular, a decreased likelihood of nurses reporting dissatisfaction and/or nurse burnout; increased levels of patient satisfaction; significantly reduced mortality/morbidity rates. The college believes the Magnet system provides a tried and proven way to address a number of workplace and professional issues which have led to the current nursing shortage.

The college currently has a proposal for a demonstration study into Magnet hospitals lodged with the Commonwealth Department of Health and Ageing. Details of this proposal are contained in our submission, and further extrapolation can be provided. The college cautions that the Magnet concept should not be seen as a quick fix, but rather as a long-term and sustainable solution.

Secondly, to help address the nursing shortage, the college has been lobbying to improve clinical education for new graduates and practice/education links. It is undisputed that the provision of quality clinical placements and clinical supervision for students and new graduates is an absolutely vital part of nursing education. Reform to clinical education needs to be addressed in two ways: first, by strengthening partnership between education and employers of nurses. This could best be achieved through the establishment of specifically designated clinical nurse educators and clinical chairs of nursing in all settings in which the undergraduate nurses receive clinical supervision. Second, it could be addressed by the expansion and maintenance of transition nursing programs, or graduate programs, which exist in a number of jurisdictions with varying success. Identification of successful models for transition programs would assist in determining the most effective approach.

The third strategic measure to help address the nursing shortage involves credentialling of advanced practice. Credentialling of nurses working at advanced practice levels and accreditation of related education programs occurs in nursing in the USA, the UK, Japan and Canada, as well as in most other health professions around the world. This is because these countries recognise that it is the profession that is accountable to the public for ensuring that nurses demonstrate agreed professional standards. A system of credentialling, while enabling

education institutions to maintain diversity and flexibility in educational models, at the same time ensures that nurses who work at an advanced level are able to demonstrate their competence and are publicly accountable.

In addition to the issues outlined above, the college would like to make a further recommendation based on our view that it is imperative that there be a chief nurse position created at Commonwealth level. It is evident now that there are global issues affecting nursing, and that no country is able to be isolated from these global changes. While the college has taken an active role in participating and responding to nursing issues at an international level—through its representation at, and active involvement as a member of, the International Council of Nurses—having an identified nurse in a national position ensures a direct link with government and, therefore, a coordinated national response to global movements.

CHAIR—Thank you.

Prof. Lumby—You have the advantage of the submission that we put in, so I have an overall statement. Since 1993 we have had 13 inquiries, special reports and research into nursing and nurses, and many of those recommendations will be the same from here. They certainly are coming out of the major National Review into Nursing Education. They are the same recommendations. In the Reid report recommendations, only one out of 41 were ever implemented.

That points to one of our fundamental problems: an inquiry into one group of the work force in such a complicated system as health care will not answer the question. It depends on a major inquiry into health care itself, and into the work force and health care—not only one group. The actions from the recommendations rely on other groups in the health care system and we do not tend to get that same support. That is the major problem because we are upsetting balances of power. We do know that the key indicator in all the research of measures of quality is the nurse. That is the person who makes a difference.

The majority of the generic concerns expressed by the public, which we see in the media every day, or issues raised by nurses themselves could be resolved in some way if more fundamental environmental and infrastructure issues were addressed, and when I say environmental I mean culture too. I think the federal government's reduced responsibility for nurses and nursing—for example, not having a chief nurse that used to be available before—leads nurses, rightly or wrongly, to feel very marginalised when it comes to major political decisions in health care. One of the issues that is raised often is the incredible amount of funding given to GPs—for example, by community nurses—and probably 89 per cent care in remote areas is given by nurses on a 24-hour call-in basis.

States which after all are reliant on national agreements do not seem to have the power to make wholesale changes to the systems but the funding of nursing, of course, is a state responsibility. My suggestion or recommendation, or the college's, would be that, to get sufficient political will, we need a more multidisciplinary approach to funding, to education, to models of care and to professional development. Then you get a system that more likely addresses the needs of the patients which is what a public health care system should do—after all, the public fund it—rather than the needs of the professions. I think that is often a problem.

Such a shift, of course, would assist cultural change. It might affect the respect for individuals who are working in a multidisciplinary team, who would be recognised for their expertise and contribution, and would result in teamwork. Certainly the areas where you see the most satisfaction and the lack of turnover of staff are in good multidisciplinary teams. All this is researched and there is evidence. We also have evidence that nurses leave the work force because of the patriarchal type of culture, and that is clearly evidenced. Senator Tchen, that report you were asking about is a report that the New South Wales College of Nursing did. It is in my document in our submission if you want to look that up. It was 30,000 nurses we surveyed, not 10,000. It is a nice powerful study.

Senator TCHEN—I acknowledge that.

Prof. Lumby—There is lack of validation of their contribution and lack of equality in terms of in-kind support such as support for conferences. I think workplace change is well overdue. You have heard that. Change and recognition are the major shift in patient profiles: a change of the nurse to a very educated, articulate professional who stands beside other health care professionals with the same qualifications—undergraduate degree—and goes on to further that. The commodification of health care is resulting in a push to privatisation and a shift of the burden of care on to consumers. The association did address this issue of needing to have some equality in salaries and recognition if we are going to have a dual system of private/public. We have to recognise equality in salaries and workplace.

All individuals entering an environment of care—this is my final statement—deserve the highest quality care possible. Australia has a high quality system but it could be a lot better and their care should be safe, effective, appropriate to their needs and individually focused. That means that professional groups need to accredit or credential their practitioners. I think anybody who claims they are doing nursing work has to take some responsibility for that so we can give the public the trust they deserve when they hand their lives to us.

CHAIR—Thank you. What is the relationship between you and Mrs Foley's team?

Prof. Lumby—We are a state body for New South Wales and we have a major educational arm. Dr Ferguson is the director of educational services. We put 6,000 nurses through graduate certificate courses each year. We have a major educational arm. We have a major professional membership arm and we certainly are very involved in the political struggle within New South Wales.

CHAIR—Mrs Foley, according to your submission, you have moved away from education?

Mrs Foley—That is right. Our primary focus now is continuing professional development for nurses and policy analysis and development.

CHAIR—I was interested in your comment, Professor Lumby, that anybody who is in the nursing area really ought to be accredited. That kind of contradicts comments—probably not, but I would be interested if both of you would comment—by witnesses from the New South Wales Nurses Association, which covers everybody who has 'nurse' in their title, they said, including the AINs or the PCAs, the patient care assistants. I can see how it does happen—it

happens all the time—but is that the sort of area you might be talking about where people may be covered by a union but are not accredited within the nursing arena?

Prof. Lumby—Yes, that is right. I would also parallel that with saying that they need to be educated at competent levels. 'Nurse' is used so loosely. It can be a verb and a noun. If you use 'doctor' as a verb—

CHAIR—If you use it in a verbal way, it is very derogatory.

Prof. Lumby—Exactly. One of our biggest drawbacks has been that everyone can nurse—if you breastfeed, you nurse; there are nurseries. I think it is very problematic, and I have some views on what we could do about that. Given that, people will claim to nurse, and I think it is about public trust. It is a huge debate within the profession—and the college, of course, is out on a limb on it, in a way, because there is still some discussion about where we sit on this—but I think we have to come to terms with it in some way, whether it is through education or credentials.

CHAIR—We have also had evidence given to us in a number of public hearings that the poison legislation in the states restricts the sorts of medications ENs can administer, with RNs being able to do the lot. As the law is silent about AINs or patient care workers, they are now being used in many cases to administer medication. That would seem to me to be a major concern in the area you are talking about.

Prof. Lumby—Absolutely.

CHAIR—Can you give us any other examples of unqualified people?

Dr Ferguson—I think there is a grave concern. If anyone has 'nurse' in their title, as in assistant in nursing, the public believe they are being cared for by a nurse. Dare I say it, we call them nurses—people who work in nursing homes, in particular. I had a conversation recently with a director of nursing about how we were not looking after their nurses, and she was referring to their assistants in nursing. The patients believe they are being cared for by a nurse, probably by a registered nurse, yet many of the people do not even have the Certificate III that was in the Aged Care Amendment Act. It did not go through, I believe. So not all of the assistants in nursing have qualifications, yet they are being asked to do dressings and to give out drugs. In many places, the expectation is that they perform as a nurse, and that is without qualification as to what type of nurse.

Senator LEES—That is one of the issues I was going to take up. Where are we along the road of making sure these assistants are actually qualified? The previous witnesses from the union discussed it briefly but, from your point of view, where should we go now to make sure that these people are qualified, that they have been through the TAFE or equivalent program at least to a level III before they work in a nursing home?

Mrs Foley—The Royal College of Nursing, Australia, the Australian Nursing Federation and the Australian Nursing Council are currently in the process of revising a position statement that was originally issued in 1996 jointly by the Australian Nursing Council and our college in relation to unregulated workers, as we called them at that stage—the title now is 'unlicensed work-

ers'—because of the very real concern of what has been mentioned here; that the public is not aware that they are not always being cared for by a registered, qualified member of the nursing staff.

Senator LEES—Are there insurance issues for the nursing homes themselves, regarding people who basically have no qualifications?

Mrs Foley—We believe so. From a professional point of view, it is of great concern. We see it as a compromise of care. However, in our statement that we are preparing we specify that these people should have at least a minimum qualification consistent with the AQF level qualification—certificate level 3, which has been talked about here. The difficulty then comes in enforcing that. Recently, when we met with the Review of Nursing Education they asked us how we might go about trying to enforce that. We suggested that perhaps a good way—because this is so bound up in patient safety and quality—would be for the Australian Council on Safety and Quality to take a very real interest and perhaps a lead in this issue.

Senator LEES—Do these people even have to have a first aid certificate?

Mrs Foley—Not necessarily.

Prof. Lumby—In answer to your question, chair—and, Senator Lees, this might be of interest to you—an analogy is that it is about the duty of care or the level of care you can be judged on. Recently, school nurses came to ask me to assist them because they felt they were being nudged out. I met with the headmasters—of the major private boarding schools mainly—where they have a school nurse in the residence for the boys or girls. The majority of them happen to be boys' schools. Increasingly those schools are taking disabled children, as you can imagine, because more disabled children are going into normal streams. The nurses are doing things like changing positions of children who need to be moved from side to side at night because of pressure areas. The headmasters told me that increasingly they are not going to be employing registered nurses. Nurses are giving medications for asthma and a whole variety of diseases and they and the headmasters would be legally responsible if something went wrong, whereas if they just get a housemaster or housemistress who is untrained, they are then measured at the level of care of an ordinary man or woman, not a registered nurse. This is what litigation does.

CHAIR—This therefore reduces the liability of the institution.

Prof. Lumby—Absolutely, and that is what they are going to do. They have a lot of students who play rugby, who have fathers who are orthopaedic surgeons or neurosurgeons standing on the sidelines. They used to come onto the field if there was a fall. Now they all stand and nothing happens. The housemaster goes onto the field because nobody will touch a child.

Senator LEES—Even with a neck injury?

Prof. Lumby—That is right, even with a neck injury. The doctors' best advice is not to go near the child in case something happens. It is an interesting issue for us and I think it goes to the heart of this question as well.

CHAIR—It is counter-intuitive.

Prof. Lumby—It is.

CHAIR—It is also probably obscene, one would have thought.

Prof. Lumby—That was my statement to the headmasters. I thought it was dreadful. I said, 'Do you advertise to parents who entrust their children to you that you do not have a registered nurse in the boarding school?' Because people would still believe that there was a matron.

Senator LEES—Particularly with the level of medication of kids these days and the numbers of children on not just ventolin, but preventative asthma medications. As a former teacher in the New South Wales education system, it was compulsory that all schools had—well, the preference was for someone with Royal Life Saving Society respiratory training and a first aid certificate. Indeed, we had to come out of Sydney University with a Saint John Ambulance certificate. So, where is all that going? Is that going down a similar path?

Prof. Lumby—I do not know, as far as education goes.

Senator LEES—I understood that in the public system it was compulsory that each school have a first aid attendant and that that then became a nurse available. Is that not the case?

Prof. Lumby—That is not happening. That is no longer happening; the teachers are doing it. Teachers are giving medication.

Ms Brans—This is an example of the sort of environmental and cultural things that we wanted to raise. Because nursing encompasses so much across the lifespan, any changes in society have a trickle-down effect—or a ramming, car accident type effect—on nursing. It is one of the frustrations that we talk about all the time: nurses are not able to act to the level of skill that they have, either because they are told that they cannot or they are fearful of litigation. In our experience, most nurses want to and they find it a source of great discomfort and distress that they cannot provide the care that they know they can. We are talking now about the metropolitan areas. The situation in the rural and remote areas of Australia is different; for example, a nurse in a very remote area is often the only person there and if they do nothing, nothing happens. So their constraints and their level of education and the things that they operate under are not the necessarily the same as in the metropolitan areas.

I take this opportunity to go back a little further, to one of your questions, Senator Lees and Senator Crowley, about what we might do about the assistant year nursing level. The college has suggested and lobbied for closer articulation between the levels of nursing, so that it is a more obvious career path for people—so that it is not seen to be better to be stacking shelves in the supermarket, because you get more money doing that, than starting a level of nursing education that can then take you further.

Senator LEES—We have had some interesting models today, from TAFE and from the universities, looking at exactly that. The models have various step-off points where people can leave after becoming an enrolled nurse, go back in and then move in and out. One of the obvious step-off points is after someone has finished university. There seems to be a very high attri-

tion rate at that point. Some of these issues have been mentioned in your submission. Can you give me a couple of real priorities that we have to deal with to hang on to these fresh out, newly graduated students? We are still not getting enough people into nursing, and that is not because of lack of applications. In New South Wales at the moment you have floods of applicants who are quite well qualified and the universities are not being funded to get the places. If we could just hang on to the ones who trained we would be streets ahead, but we are not doing it. I do not know what percentage in New South Wales drop out after they have qualified, but I know it is a big percentage. What can we do about that?

Prof. Lumby—There are two issues. Once more, it is a global shift. I have three daughters and I have watched their careers; they move in and out of careers. People do not stay in a career for life. I was a nurse who did. My generation is gone. It would be the same for you, Senator Lees, in education and, I would think, in teaching. People do not stay in it any longer. I have a brother and sister who are teachers. Women, particularly, move in and out and across boundaries, so they might be in a related area of health care, but not nursing. So I think we are seeing that, which is a global change to society.

The other issue, according to the research we have done in follow-ups, is that the culture of the system is a great shock to them. Once more, it is about the culture of the system I spoke about before. You have articulate, educated people going out into a system that is very caught up in the past. There is no recognition of the change in women's place in society or of the fact that there is a change in the education of the nurse. The culture places them at a level where they cannot speak out or are not involved in senior decision making, but are asked to implement the results of that decision making.

So there is that problem, and I think the long-term solution to this is multidisciplinary education for our health work force. If we brought people through in an undergraduate degree together, I think we would have an understanding of each other's roles and we would be more likely to be able to work in teamwork.

Mrs Osmond—One of the other things that I heard mentioned earlier is the fact that a nurse is a nurse is a nurse and, particularly with the shortage at present, there is an expectation that that newly registered nurse comes on as in charge of shift within weeks of having been employed in that area. That is a frightful situation. Interns are not expected to take that level of responsibility in their first few weeks out, yet nurses are. Being put in that situation, and the ramifications of the decisions these young nurses are making, frightens them to pieces and a lot of them walk away thinking, 'I'm not up to this'. If this is the expectation of the role of the profession they will get out then rather than be helped through, because there is not that other higher level of support and those more senior registered nurses at this point in time to support them through that and mentor them through it. It is a real catch-22. Something needs to be done in the short term but we also need to look at the longer-term solutions.

Mrs Foley—I refer to the transitional programs that I mentioned in my earlier statement and that we refer to in our submission. The college believe very strongly in establishment across the board of transitional programs, and I am not just talking about a particular defined period. People often talk about graduate programs or a transition year. We are not actually specifying a time frame, because it may be very dependent on the individual involved. What we are concerned about is that resources be put into nurturing and education of our new graduates. We see this

very much as being resources well spent. There has already been quite an investment in these people with their tertiary education. Particularly now that the government is providing scholarships for rural and remote people there is even more of an investment. We see that it is therefore important that additional resources be put into the nurturing and education of these people so that we do not lose them.

There must be an emphasis on retention, otherwise it is just like a colander and pouring more people into a system where they are not going to be appreciated and valued and they are not going to be able to use the educational preparation on which they have spent three years. As a profession we have seen that it was important that nurses come out of the apprenticeship style system and receive a much more broad based education in the tertiary sector, but when people come into the system, as Judy said, there is a culture there of not accepting this newly graduated person for what they are and for the contribution they can make. They are safe practitioners and they have been assessed against the Australian Nursing Council minimum competencies, but they need to be nurtured to become competent practitioners.

Ms Brans—The Magnet Hospital proposal that we put is a means of doing that, and in other undergraduate programs that exist around the country there are some models of things that are actually working. We would like to see those strengthened.

Senator TCHEN—I think the evidence the ladies have given about the public liability aspect might be of great interest to the Attorney-General!

Prof. Lumby—Better wipe my name off that statement.

Senator TCHEN—You are under parliamentary privilege. I would like to ask a question first about cultural changes, and this is related to workplace violence, horizontal violence particularly. This is a question which I wanted to ask the Australian Nursing Association as well, but you are in the same situation. Where both parties in a case of workplace violence—it does not have to be physical violence, of course—are your members, what is your role?

Prof. Lumby—You are asking the NSW College of Nursing.

Senator TCHEN—Yes.

Prof. Lumby—We are not a union and we do not have a union arm, but we have a lot of people ringing us about supporting them in this area. In particular, my senior staff are highly qualified to counsel people, so we would do more counselling and give them suggestions on how to manage workplace violence. Certainly, in my past role as the clinical chair I did a lot of work talking with people about strategies.

Senator Tchen, I listened to the questions, and I know the horizontal violence stuff that we all talk about. I have a position on this: I think we should stop talking about it, because the more we talk about it the more we will perpetuate the belief and the image in nursing that that is what we do. I have been too involved with medicine not to know that it goes on there, but they just manage it better and they manage it by keeping it behind closed doors. I am sure it goes on in your activities—

Senator TCHEN—Not in the Senate!

Prof. Lumby—Of course not. Some of it becomes public. It happens in teaching; it happens in every profession. I have three daughters in other professions—it is just as bad there. For some reason it has surfaced here, there has been a bit of research on it and now we seem to be branded with it. I feel very sad about that, actually, because I have been in nursing forever. It does not mean that because I have not suffered it, it has not happened, but I have worked in teams where they have worked so well and supportively, so it is sad that it is coming up all the time as a major question.

Mrs Foley—I think Judy is right: we should not place a disproportionate emphasis on horizontal violence. I think that violence per se is a really important issue in nursing. This was recognised globally by the International Council of Nurses last year, their theme being 'United against violence'—that all nurses should work together to be able to do something positive about the violence that they encounter. Very often, that actual physical violence can even be death, as we have seen in Australia.

Our college has run workshops on violence, to assist nurses in the way that they can manage episodes of violence in their workplace. We have an interesting publication on violence as well. I was just assisting in our response to a draft document—I cannot think the correct title, but Stephanie may be able to correct me—in relation to violence in rural and remote health care settings. There is an increased importance on the management of violence in those sorts of settings because nurses are so isolated from the necessary resources and from security personnel who may be able to assist them. In remote facilities, they may be entirely on their own. So we need to consider those issues.

Ms Dakin—It was an NHMRC document. I cannot remember the title, but basically it was about dealing with violence.

Senator TCHEN—Professor Lumby, in politics we institutionalise horizontal violence. It is called question time!

CHAIR—It is nothing compared to what goes on within your own ranks.

Senator TCHEN—That is called the party room!

CHAIR—That is not a good example at all.

Senator TCHEN—I think it was Mrs Foley, from the Royal College of Nursing, who indicated that funding for continuing nurse education scholarships for rural and remote areas is inadequate. How much more do you think needs to be done?

Mrs Foley—I guess it is difficult to put a dollar figure on it, but at the moment about half a million dollars per year is allocated to postgraduate education—that is, conferences, seminars, tertiary education, short courses, exchange programs et cetera. We receive applications for more than double that amount, so I think that gives some demonstration of the need. This is just rural and remote people; if we were to add all nurses in Australia, you would see the need being enormous.

Senator TCHEN—Is the need greater and more urgent in rural and remote areas?

Mrs Foley—Yes, because of their inability to be able to easily access educational programs.

Mrs Osmond—And not only access their role but the ability to be replaced is one of the biggest problems that we have with our students from rural and remote settings. There is workplace support for them attending. There is sometimes funding for them to attend but the lack of a body to replace them simply precludes them from attending.

CHAIR—Who is to be replaced?

Mrs Osmond—A registered nurse to replace that registered nurse.

Prof. Lumby—Remote and rural nurses work in communities where they also live and they meet their patients in the supermarket. This means that, if they have to close a clinic or if they are not there for several weeks, they feel a huge responsibility and they will not leave.

Senator TCHEN—Can you suggest some ways of perhaps overcoming this problem—something like a circuit nurse replacement?

Prof. Lumby—That is a good idea—travelling circuit nurses.

Ms Brans—I thought of that. One of the things that the college does that the Commonwealth has funded—and it has had a marked impact already—is the Commonwealth Undergraduate Rural and Remote Nursing Scholarship Scheme, which you probably know was implemented for the first time this time around. We have had an enormous response to that. We would expect that those people will be retained and recruited in the rural areas. Part of that scheme is to establish a mentor scheme for the recipients of the scholarship. We are expecting that that will help to retain the qualified nurses in the rural and remote areas because we are going to actively link up with them. Any support for more funding in that area would be really good. But I think one of the things we need in relation to that is someone who can go around like the School of the Air teachers—they do it voluntarily, I think. Something that is more formal than that would help.

CHAIR—Did you have an enormous response?

Ms Brans—There were 110 places and of those 10 were specifically to be allocated to indigenous people. Within a month, we received 1,014 applications. We have awarded 15 of those scholarships to indigenous people. The new minister, Kay Patterson, awarded an extra 30 for that. So there is a total of 140 this year.

CHAIR—Are they Australia-wide applications?

Ms Brans—Yes.

Senator LEES—I met one recently who must have been in the mentoring program; this was in her first short break. She was already going back to the hospital in the rural area in South Australia and 'this is my hospital already' was her attitude.

Ms Brans—We have had some heartrending letters back from people to say, 'This is absolutely wonderful; it's been my dream. I could never have been a nurse if you hadn't given me this money.' I have spoken to parents who spent their Christmas holidays sitting down at the kitchen table working out their budget to see how they could possibly scrape together the money to send their daughter off to nursing. After she gets a scholarship, she can go. It is just amazing.

Prof. Lumby—The other thing is that we are putting a lot on the line.

Dr Ferguson—We are doing a lot of distance and online education. There are some inequities, particularly between medical and nursing staff. I was in Tamworth recently. The Sydney intensive care doctors fly to Tamworth to cover the weekend. They are paid twice their salary plus living and accommodation. And yet there is no budget to replace someone who runs, as a sole practitioner, a nursing clinic in Wanarring, so that they can come down for a 10-day workshop. Those inequities, particularly for the remote people, need to be addressed. They need to have a locum service so nurses can be replaced much the same as they have a locum service for doctors and physios.

Senator LEES—This is why we pushed for those 100 nursing scholarships to make up for all the scholarships that doctors have got over the years. Now we need to go out for podiatrists, physios and radiologists. There is a whole lot of other rural work.

Prof. Lumby—That is the problem—

Senator LEES—One of the reasons doctors will not go is that there is not a nurse. One of the reasons a nurse will not go is that there may not even be a pharmacist. That position might have been sitting there empty forever and a day. So the nurse will have very little support.

Prof Lumby—That is why we need an integrated approach to the work force. It is no good doing these isolated inquiries.

CHAIR—I just wanted to follow your response to Senator Tchen's suggestion that there should be a circuit nurse, or something of that sort, which created an idea in your minds that, it seems to me, is different from the locum situation. Would you care to consider that and drop us back a piece of paper about it. I certainly think the old locum way is just back-filling gaps, but the circuit notion seemed to be maintaining and keeping other people out there and so on. So if you would not mind preparing something, not a thesis—

Prof Lumby—I bet you have had many of those.

CHAIR—We will not have the capacity to read it, but also I do not want to give busy people more work. However, if there are some dot points that you might put together in response to that suggestion then I think that would be very good.

Senator TCHEN—One quick question for each of you. Professor Lumby, it has been suggested that a specialised Bachelor of Midwifery degree would help to overcome the shortage of midwives. Do you support that idea?

Prof Lumby—I certainly don't not support it. There is no reason why I would not support it at all. I know of that. It is a direct entry midwifery program that has worked in other countries. Whether it will help the recruitment of midwives or not I do not know because we have not tested it here. I do not know if my colleagues support it. The college has discussed it. We do not have a particular college view on it because it is up to the midwives to make those decisions.

Senator TCHEN—Mrs Foley, in your submission you propose a Magnet Hospital Recognition Program—which apparently worked well in America—to be tried here. I have a small problem with that. Again, it is a cultural thing, but it seems to me the American approach to things is whoever can stand on their heels and thump their chest the most, everyone listens, whereas here we are looking for a peer or collegiate approach to things. Do you think that American approach will work?

Mrs Foley—The college is aware that there are many people who, as soon as you talk about an American system, throw up their hands. However, since our submission was placed with you—or even before then, but certainly there has been a lot of work since then—there has been a pilot program in the United Kingdom. People seem much happier comparing our system with that. The report of that pilot process is soon to be released. So we are looking forward to that report, which will give a different perspective because it is coming from a different culture. People tend to think that our culture is more like the UK, rather than our health system. I think the results of that particular project will be very informative for us.

Prof Lumby—Senator Tchen, quite a few hospitals in NSW are already adopting some of the issues out of the Magnet hospital study. They are actually quite common sense things about valuing colleagues—

Senator TCHEN—Yes, I understand that; I am just saying that it is a national program.

Prof Lumby—So that is happening. A couple of private hospitals, in particular, are doing that and they are evaluating those.

Senator TCHEN—Hospitals and universities have always done that but not as an officially sanctioned program as such. They are always trying to achieve excellence and bring other people along as well. Senator Crowley has often used this example about nurses in the old days being St Vincent-trained nurses or—

CHAIR—RPA.

Senator TCHEN—That is right, and how that carries a particular prestige.

Mrs Foley—The essence of the Magnet program goes beyond a demonstration of excellence. What it means for nursing is that nurses are valued by the whole multidisciplinary team within the particular institution. Their clinical decision making and their professional development are supported, which we do not often see in our system today.

Senator TCHEN—Can you please supply us with a copy of your survey?

Prof Lumby—Yes, certainly.

CHAIR—Can I ask either or both of you to tell us, in 30 seconds, what you see would be the specific functions of a chief nurse?

Prof. Lumby—I would see that they would have a direct line to the minister for health and provide advice. They would have an advisory committee to report to them on issues in the states because, as you probably have heard, for very good reasons our nursing funding and politics are state based. I think those issues could go to the chief nurse, who would then directly advise the minister for health on how they meet national and political—

CHAIR—In other words, it would be someone in the federal department who would be in your corner?

Prof. Lumby—Yes, and that has happened in the past. We have had a chief nurse before. Paulina Pilkington was there for seven years. Some of you might know her as the flying nun. She was there working with Sidney Sax and wrote the Sax Report which moved us into university.

CHAIR—Those of us who are old enough, yes.

Prof. Lumby—She was quite dramatic. She probably said a lot of prayers for all you senators.

Mrs Foley—Although there are many nursing groups who lobby the bureaucrats in Commonwealth government and the ministers and senators, this central position, because it would be a position within government, would not be seen to have the vested interest that you might see coming from groups that—

CHAIR—I would have thought it would be seen to have nothing but vested interests, Mrs Foley.

Mrs Foley—Exactly. That is what I am saying. This person would be seen by government not to be carrying any of those sorts of issues and would be able to analyse issues across the board. In addition to the national importance, there is also an importance in the international scene at the moment. Australia is compromised in many settings because we do not have a nurse in that position.

CHAIR—I am going to have to rush so please excuse me. Reference was made earlier to expos being conducted by the royal college in selling nursing generally and specialties in particular. To whom are these expos directed? Have they been successful in attracting rural nurses? What other strategies are you using to try and recruit nurses, particularly in rural areas?

Mrs Foley—The expos have been very successful in being able to promote the range of opportunities within nursing. The target audience are people who are potential students of

nursing—so they are secondary school students and their mums and dads come along—as well as people who are already in undergraduate nursing programs who are exposed to the range of specialties and the range of educational opportunities and people who are already registered and enrolled nurses who may wish to seek a career change.

CHAIR—Do you also focus on trying to attract into nursing mature age people who have even perhaps been in another profession?

Mrs Foley—Yes. I guess I have very much defined those three groups. They are the three broad groups but we include obviously anybody in the public. The expos are open to the public and we endeavour to advertise as broadly as possible so that anybody who has an interest in nursing can come and see the excitement that the nursing profession provides.

CHAIR—We had a lovely word today from another witness when she referred to the passion for nursing. Do you have anything equivalent to the medical indemnity for nurses?

Mrs Foley—Yes. There are professional indemnity offerings available through our college and through the Australian Nursing Federation.

CHAIR—But most nurses working in large institutions would be covered by the institutions?

Mrs Foley—Yes. I have knowledge of this, not personally thank goodness, but through colleagues. What we advocate is that even though nurses within an institution may have vicarious liability cover there is not always the opportunity for them to have representation as a nurse. The representation will be for the organisation and that can be a very real problem. There are many instances when nurses have not felt that they have been appropriately represented.

Ms Brans—There have been some reported instances where a hospital or institution has successfully been sued and had to pay damages and then that institution has sought to have the person concerned pay back those damages to the institution so although vicarious liability might be there, there has been that attempt.

CHAIR—Can you provide the committee with any examples? Perhaps you leave out the names.

Ms Brans—I can find them for you.

CHAIR—That would be fantastic. I wanted to ask you the following sorts of questions and, at this stage, maybe we need to put it on notice unless you can answer, 'Yes' or 'No', very quickly. National registration? Are you in favour of it, against it or not interested in national registration?

Prof. Lumby—I think it is problematic because nursing is state based.

Mrs Foley—We are not opposed to it, but there are a lot of constitutional changes which would need to take place.

CHAIR—National curriculum?

Prof. Lumby—This imposes things on nursing which are not imposed on other groups within health care. There is enough inequality; let us not create any more.

Mrs Foley—It diminishes creativity.

CHAIR—Who said it damages creativity?

Mrs Foley—It diminishes creativity.

Ms Brans—It does not allow one of the important things. The health industry is saying to the academics that the curricula are set in stone, and they cannot respond rapidly to the local needs of the industry. If there were a national curriculum, that would be worse and would further diminish the capacity of nurse recruitment and retention.

Dr Ferguson—We do have national competency standards to which all universities work. That is a better way because they can be creative, but they have the same outcome standards to meet.

CHAIR—I am not clear from reading both of your submissions what your relationship is to the registration boards, what your relationship is to universities and/or TAFEs and what your relationship is to the unions. I suspect it is probably phone calls rather than anything else.

Prof. Lumby—Yes. I can quickly tell you what ours is. In New South Wales we have an affiliation agreement with the New South Wales Nurses Association and are closely linked with them. We do a lot of professional development with them. In terms of universities and TAFEs, we are linked and do articulated education. They see us as a ground for their graduate diploma and masters students. We particularly articulate with the universities and the other way with TAFEs. We do a lot of that work, so that nurses do not have to jump 29 hoops and they can articulate their work through. Fourteen universities directly recognise our graduate certificates to masters level.

CHAIR—Do you design the masters or do you teach them, or both?

Dr Ferguson—We provide graduate certificate courses in specialty nursing. We have 24 different specialties.

CHAIR—Provided where?

Dr Ferguson—At the New South Wales College of Nursing in Sydney. We have 6,500 students a year and 1,200 of those take out formal award courses. Many of them do progress then to diploma and masters at the universities.

Prof. Lumby—Some of those were involved in the curriculum writing.

CHAIR—If you had a bit of paper that made me understand where you fit vis-a-vis universities, that would be helpful. I am doing my best, but every time I have another witness I get to realise that it is even more complex than I thought, and I do not want to do injustice to both of your relations.

Mrs Osmond—The graduate certificates we offer are under the Australian qualifications framework and we articulate into that. We offer that first level, if you like, of postgraduate education that often universities cannot provide at that specialist level because the level of faculty they would have to have to do that precludes them from undertaking it.

CHAIR—Is this 16 weeks, 12 weeks or two years?

Mrs Osmond—It is one-year part time.

Prof. Lumby—One-year part time. We bring in registered nurses who are working in the workplace who are up to date clinically and who are expert nurses. They run the courses. We second a lot of them and then they go back. We have clinically relevant courses. We try to maintain those.

CHAIR—If there is anything further about that, can you provide it?—again, a bit of paper already written and not a thesis.

Mrs Foley—The Royal College of Nursing participates in a national peak nursing forum, which began about 18 months ago. The members who participate are the Australian Nursing Council, the chief nurses from each state and territory, the Australian Council of Deans of Nursing and the Australian Nursing Federation. In addition to that, and more personally, our college has a memorandum of cooperation with the Australian Nursing Federation. In addition to that, and more personally I suppose, our college has a memorandum of cooperation with the Australian Nursing Federation.

CHAIR—We must finish. Thank you very much for your contribution. Can you drop us a paper about the state of IT and the nursing profession. I am sorry it cannot be done now. We have another witness and we should have finished 10 minutes ago. Could you provide us with an outline of where it is and where you are hoping it will go. Thank you.

Prof. Lumby—Thank you for the opportunity.

[4.56 p.m.]

LYON, Mr Michael, Managing Director, Australia and New Zealand, Becton, Dickinson and Co.

CHAIR—Welcome. The committee prefers all evidence to be given in public, but if you wish to give evidence in camera you may ask to do so and the committee will give consideration to your request. I remind you that the evidence you give to the committee is covered by parliamentary privilege and that if you give false or misleading evidence that can constitute a contempt of the Senate. The committee has before it your submission No. 966. Do you wish to make any alterations?

Mr Lyon—I wish to make a statement.

CHAIR—You have about three minutes, so we can have about two minutes for questions. If you could accommodate that request, that would be very helpful.

Mr Lyon—I will do my best. Thank you for the opportunity to appear before the committee. BD is a global medical technology company with over 65 years of experience in the development of safety technology for use in the medical health care worker environment. Because of that leadership position not only in Australia but worldwide, we believe we have an obligation to use our knowledge and skills in partnership with other organisations involved in reducing the number of preventable needle-stick injuries and other sharps injuries occurring daily in our hospital system. In 1998 at least 13,300 nurses and other hospital workers underwent the psychological trauma of suffering a needle-stick or other sharps injury. Conservatively, one in nine nurses employed in Australian hospitals will accidentally stick themselves with a needle or other sharp this year. This estimate is based on research by the National Centre in HIV Epidemiology and Clinical Research.

Nurses are an integral part of our community, as I am sure you have been representing well today. They are our sisters, brothers and neighbours. They are members of the community who are devoted to looking after us. They often serve us under highly stressful conditions. Becton Dickinson believes that the community owes them a debt. It is our community responsibility to look out for them.

How do these accidental and preventable injuries occur? For those of you who have been hospitalised or know that part of any hospital treatment involves medication and the inevitable injection, nurses have an enormous amount of work to get through on their shift and experience often unrecognised emotional stress associated with looking after patients. In this demanding environment, a simple accident means that the nurse or other health care professional may drop a syringe, jab themselves with a needle protruding from a container during disposal or be injured when a patient moves unexpectedly. Despite the hospital's best educational programs and any occupational and safety guidelines in place, needle-stick injuries will still occur. They occur at an alarming rate. What is more alarming is that the majority of these injuries can actually be prevented. Picture yourself as a nurse in the course of a normal working day getting stuck by a needle. Imagine the emotional trauma of not knowing for three months whether you

have contracted a potentially fatal blood-borne disease such as Hep C or HIV. What impact would this situation have on your previously normal life?

Nurses have told BD that the hazards associated with needle-stick injury are a factor in their decision to leave the profession. As I stated earlier, these injuries are preventable. A number of area health services in New South Wales and other states have recognised the urgent need to provide a safer working environment for their staff and have introduced safety-engineered needles and other products into their hospitals.

This trend will continue. My question is whether the pace of change is quick enough. I understand that the committee will question the costs involved in conversion to safe needle technology, and the ongoing hospital staff education. My response to that is simple. BD has been told that for a large teaching hospital in Brisbane the cost of change will be less than one per cent of that hospital's total budget, which will result in the reduction of up to 85 per cent of all needle-stick injuries in that hospital. The enormous benefits of preventing just one needle-stick injury from occurring would make this additional expenditure worthwhile.

I would hope that this committee could focus governments to ensure that this happens. State, territory and federal governments only need the will to change. In preparing our submission to the committee, BD ascertained the views of state and territory politicians on needle-stick injuries in hospitals. We were shocked to discover the great divide between the attention given to incidents involving discarded needles in parks and beaches, and that given to nurses and other health care professionals who are potentially exposed to needle-stick injuries every single day. Why are needle-stick injuries that occur in hospitals considered less important? Nurses and other health care professionals are the people devoted to helping us when we are sick. All nurses and health care workers have the right to access the safest needle protection technologies available. Occupational hazards associated with needle and sharps injuries in hospitals are viewed as a serious problem in the United States and in Europe. I do not understand why Australian health authorities do not share this concern.

In April 2001, the United States government passed the federal Needlestick Safety and Prevention Act, mandating the use of safety engineered technology in hospitals, when the devices had proven to eliminate or minimise occupational exposures. Similar compulsory requirements are expected to be introduced in the Spanish hospital system within the next 12 months. The UK, Italy, Germany, other European countries and Canada are working towards the same goal of implementing safe needle technology in their hospital systems within the next two to three years. Why should health care workers in Australia not be afforded the same the protection?

There is another important reason why Australian hospitals should introduce safety engineered technology, safety engineered needles and sharps. This is the obligation of hospital administrators in ensuring a safe and hazard free work environment for nurses and other hospital staff. Occupational health and safety protocols, in place in all states and territories, are based on risk management. Hospital management, including public and private hospitals, must identify and assess any risk to employees and take whatever steps are reasonably practicable to eliminate and control the risk. In assessing this, management is required to recognise the human element of the work process. This means that there is an obligation to look after the careful and

competent hospital worker as well as the careless and inadvertent. If it is possible to eliminate the risk of needle-stick injury by using safety engineered needles, then this is what is required.

Here in New South Wales under the OH&S Act, hospital board members and the senior administration staff of a hospital are deemed to have committed the same offence as the hospital corporation by virtue of their respective positions. In other words they, too, can be sued by a nurse or other hospital worker as a result of an accidental jab with a needle. It is difficult to estimate the cost to the Australian hospital system of litigation resulting from an injury, as most of the compensation lawsuits have been settled out of court with the usual confidentiality requirements. Needless to say, the cost is significant and when combined with the cost of diagnostic testing necessary for any needle-stick injury, the health care system is placed under further strain.

Finally, safety engineered technology alone does not necessarily reduce the risk of injury. BD recognises that. However, if used in conjunction with a supportive and complementary education program, there is no doubt it will significantly reduce the risk of injury in our hospital system. BD agrees with the Australian Nursing Federation as it was reported in today's *Canberra Times* as having said that:

... hospitals and health services needed to invest in technology to protect staff.

That was record time, senators, and I thank you for that time.

CHAIR—Thank you very much, Mr Lyon. Some of us have had the opportunity to find out a little bit more from you and from other sources about the sharps injuries. We very much appreciate you having the opportunity to put that on the record and we also have the comprehensive material that you have provided to us in your submission.

Senator LEES—Have you got a sample of the technology?

Mr Lyon—I did not bring a sample with me.

Senator LEES—Could you drop one in because I would like to have a look at what we are talking about.

Mr Lyon—We have several types.

Senator LEES—Could you leave them with the committee so that we can have a bit more an idea?

Mr Lyon—I will make sure you get some.

CHAIR—I particularly want to thank *Hansard* and I also want to thank the staff of the Furama Hotel for their hospitality today.

Committee adjourned at 5.05 p.m.