COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Reference: Nursing inquiry

TUESDAY, 26 MARCH 2002

BRISBANE

BY AUTHORITY OF THE SENATE

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COMMUNITY AFFAIRS REFERENCES COMMITTEE

Tuesday, 26 March 2002

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

Terms of reference for the inquiry:

For inquiry into and report on:

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

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

That the Committee specifically make recommendations on:

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

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

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

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

(v) strategies to improve occupational health and safety.

WITNESSES

Committee met at 9.03 a.m.

BARRY, Mrs Kym, Professional Officer, Queensland Nurses Union

HAWKSWORTH, Ms Gay, State Secretary, Queensland Nurses Union

MOHLE, Ms Beth, Project Officer, Queensland Nurses Union

RICHARDS, Ms Amanda Marion, Occupational Health and Safety Officer, Queensland Nurses Union

PARLE, Mr Glenn Martin, Executive Director, Best Practice Australia Pty Ltd

CHAIR—Welcome. The committee prefers all evidence to be given in public but should you wish to give any of your evidence in camera you can ask to do so and the committee will give consideration to your request. I have to remind you that evidence given to the committee is protected by parliamentary privilege and that any false or misleading evidence to the committee may constitute a contempt of the Senate. The committee has before it your submissions nos 457 and 744. Do you wish to make any alterations to those submissions?

Ms Hawksworth—No.

CHAIR—I invite you to make an opening statement, and then the senators will ask questions. I note for the record that the Queensland Nurses Union has come before the committee many times in recent times, so we thank you for your continuing commitment.

Ms Hawksworth—Thank you. I will not go to our submission in any detail. All of the information is there; however, there is some new information since our submission was made. As a requirement under the current certified agreement, Queensland Health are to provide to the QNU the number of nursing vacancies within the public sector. As at 30 November 2001, there was a reported vacancy rate of just over 800. The QNU disputed that figure on the basis that the data showed that the Royal Brisbane Hospital had only 15 vacancies at that time. From anecdotal evidence from our members at the hospital, which is a very large hospital in Brisbane, we knew the figure to be around 120 at that time. So we certainly disputed those figures from Queensland Health.

As a result of the concerns expressed by the QNU those figures were validated by Queensland Health and we were provided with that information only yesterday afternoon. Queensland Health have advised that they took a snapshot during the week starting 17 February, and there were 758 vacancies that week, despite the fact that 585 new graduate nurses had commenced over the period January to February. Queensland Health also advised that 1,230 full-time equivalent agency or casual shifts were used across Queensland Health facilities in that week.

CHAIR—What was that figure?

Ms Hawksworth—It was 1,230 full-time equivalents—that was the number of positions across Queensland Health that week. It is clear to us that the situation in terms of nursing

shortages is worsening in Queensland. In 1999, during the work done by the Ministerial Taskforce, Nursing Recruitment and Retention set up by Minister Edmond, the vacancy rate across Queensland was said to be around 500. In the private and aged care sectors—the evidence is anecdotal; we certainly cannot get figures from those areas like we do get from Queensland Health—we are certainly receiving similar reports.

Because of our concern about the state of nursing in Queensland, the QNU launched a campaign on 8 March called 'Nurses, worth looking after' and the campaign will run throughout 2002. It involves community education and political lobbying as well as the industrial campaigns that we will be involved in this year. The objective of the campaign is to rebuild Queensland's nursing work force through improving nursing wages, ensuring workloads are safe for both patients and staff, ensuring nurse education programs are appropriate and affordable, improving and making safer the workplace environment and implementing work force planning strategies that address the needs of a predominantly female and shift working work force. These five major areas are covered in our submission as solutions to the nursing crisis, and are in the 62 recommendations contained in that submission. That is all I have to say at this stage. We are happy to answer any questions.

Mr Parle—Thank you. I am an organisational researcher. I have been doing organisational research into culture and what it is like to work in organisations for the last 10 years. Back in late 2000, one of our clients, Princess Alexandra Hospital, asked us to commence a survey of nurses to find out what attracted them, why they stay and the professional and organisational issues involved in that. We have continued that process as a larger benchmarking study involving 50 hospitals and health care organisations throughout Australia and New Zealand, surveying over 11,000 nurses to date. We have had responses from 6,800 nurses and it is an ongoing process.

One of the facts that has come out of it is, for example, that 50 per cent of nurses surveyed to date are at risk of leaving the profession and, if you include the ones who want to leave their organisation, 57 per cent are at risk of either leaving the profession or their organisation at this current time. I am happy to answer questions. There is some information there—early results of the benchmarking study. We have since sent along some recent insights. We provide the reports to our clients on what they can do, but we have also issued these public documents to help nurses, nurse managers and hospital executives to work out basic strategies. We are not coming at it from the macro level; we are coming at it from the micro level, which is basically this: what can managers do tomorrow to help change the situation? Thank you.

Senator KNOWLES—There are a number of issues I would like to raise with the union, particularly your request for an urgent review of current wages and conditions of nurses in all states and territories. Because the states are responsible for those factors, have you proposed to the state government and received any feedback on the possibility of that happening?

Ms Mohle—In relation to the state government as an employer? We are presently in the process of negotiating an enterprise bargaining agreement with Queensland Health. We have certainly put a claim on the government in relation to wages and working conditions, and we can provide the committee with a summary of that, which is contained in this document. We also have an overview document. Yes, we certainly have raised the issue of wages and working conditions for Queensland Health employees. The difficulty is that Queensland Health

employees are covered by a federal award and other nurses employed in the state are under a state award, so there are jurisdictional problems for nurses who work in different sectors in the state.

Senator KNOWLES—You go on to say:

Further to this review, that necessary legislative amendment be made to the *Workplace Relations Act 1996* to achieve a fairer and more appropriate wage fixing system for nurses. That funding mechanisms for services in all sectors of health be constructed in a manner that enables movements in pay and conditions for nurses.

The difficulty from our perspective—and you have lodged a submission to the federal government—is that most of these things come down to the states at the end of the day.

Ms Hawksworth—Regarding aged care nurses, for example, what employers are telling us is that they cannot afford to pay wages that are appropriate in our view and that provide parity with the public sector. Our view is that nurses who work in aged care are no less skilled and have no less expertise than nurses who work in the public sector, but trying to get up satisfactory enterprise agreements with aged care employers is virtually impossible in some respects. If we signed up to some of the wage offers that they make, nurses would be worse off than if we simply waited for the national wage case and the state flow-ons. The wages that they are offering are so low that nurses would be disadvantaged if we did that. We have very few what we would call framework agreements in Queensland. We are negotiating a very big one at the moment with Blue Care, which is a domiciliary and aged care service. Those negotiations are ongoing. Blue Care have offered at this stage eight per cent over two years. That would make Blue Care nurses the best paid in Queensland in terms of aged care. But we have hundreds and hundreds of nursing homes in Queensland where it is almost impossible to negotiate on an individual level for enterprise agreements. That is what we are referring to: being able to deliver from the union's point of view a fair and equitable outcome for our members, particularly in aged care. Of course, the funding for aged care does come from the federal government.

Ms Mohle—There is currently a 14.3 per cent wage disparity between aged care nurses and their public sector counterparts. That is taking RN grade 1, pay point 8.

Senator LEES—That is a Queensland figure?

Ms Mohle—That is a Queensland figure. The disparity is 14.3 per cent. There is a variation, depending on what level of nurse you are looking at. Level 1, pay point 8 is pretty well standard. That is the top pay point of level 1 registered nurses.

Senator KNOWLES—It was five per cent in New South Wales.

CHAIR—Yes.

Ms Hawksworth—That is true. They have an award based system, which is different.

Ms Mohle—That is a significant point, actually, that under award based systems the disparity between the sectors has been much less. New South Wales has fared better than any other state because of the way their industrial relations system is regulated.

CHAIR—What is the parity between the public sector nurses in Queensland and public sector nurses elsewhere? So that we can compare, is the 14 per cent parity mainly because the aged care nurses are paid appallingly?

Ms Hawksworth—No, not necessarily. We have here *Nurses PAYCHECK*, which is an Australian Nurses Federation document, which does give those figures across the states. It is difficult when you have movements with certified agreements across the states, but Queensland, from where we sit, sits about third in wages.

Senator KNOWLES—I was going to ask what we are basing the difference on. That is a very valuable document, if you would be kind enough to give it to us. Also, I want to come to the question of HECS. You have talked about waiving the HECS fee until the nursing shortage has eased. There are a lot of people who would like to see the HECS fee waived. How would you propose doing that, so that there wouldn't there be a counterreaction from every other undergraduate saying, 'Well, there is a shortage of engineers or there is a shortage of this or a shortage of that. We are not going to pay our HECS fees either'?

Ms Mohle—Senator, there is no other occupational group that goes anywhere near nurses in terms of the level of skill shortages—and that is confirmed by the Department of Employment, Workplace Relations and Small Business surveys. Nurses are on the MODL, which is a document that says that you do not have to meet certain criteria in terms of immigration, for example. We would say that nursing is such an area of acute shortage. We have certainly written to the state branch of that department to find out what it is like, and there is no indication that it is getting any better; indeed, it is getting worse.

Senator KNOWLES—How would you stop the run-on of every other undergraduate—regardless of whether there is a shortage or not—saying, 'Well, if they are not going to pay HECS fees, why should I?' We are talking about human nature here. We are not talking about logic.

Ms Hawksworth—It is short term but it is also about providing a health service. We know from evidence from our members that, at the moment, surgery is being cancelled all the time because they do not have enough nurses in postoperative and ICU. My understanding from our members is that it is not unusual to be cancelling category 1 and category 2 surgery right now. It is happening all the time, simply because there are not enough nurses to look after the patients after surgery. If that is the case, then it is a critical situation for the health care of all Australians.

Ms Mohle—It is a policy decision, I guess: the government makes a determination, in terms of the level of critical shortage, that something like this is required. We certainly think that it is required until such time as the shortages are addressed, because they are across all specialty areas. There is just not one that is exempt.

Senator KNOWLES—It does not resolve, though, the issue of human nature saying, 'Me too,' does it? The 'me too' brigade would be loud and strong.

CHAIR—Senator Knowles, can I interpolate there? On that point, I wonder if you would care to comment. We have been given evidence that the problem in the nursing shortage is not so much with the cost of getting people in but with the cost of keeping them in. That is to say, there are nurses oversubscribing to do undergraduate nursing courses to become RNs, so at that

stage I would be interested in why you would see that as a HECS challenge, whereas I think the nurses who leave, or who face very big upfront costs for postgraduate nursing, seem to be a different situation. Would you comment on that in the light of Senator Knowles's question?

Ms Mohle—In Queensland, and I will check with Kym Barry in relation to this, I do not think there is much of an issue—or no more so than for any other undergraduate course—in terms of wastage from nursing as an undergraduate course. My understanding is that the wastage is no greater than in any other course. The issue in relation to postgraduate HECS is significant, and we have had conversations with nurses where they say that they have calculated to do a midwifery qualification, for example, but that it has cost them $35,000. When you take on opportunity costs such as lost wages, as well as HECS costs, they are significant. So there are very great structural barriers in terms of postbasic as well as undergraduate courses.

Senator KNOWLES—What we are driving at here is that we have had evidence wherever we have gone that most of the schools of nursing have in fact been oversubscribed—which would lead one to believe that it is not a case of not being able to encourage people to go in. In some cases, we have had quite alarming evidence of the scores being dropped and dropped and dropped, and so nursing can almost become a viable option of last resort—which is exactly what we do not want. The oversubscription side of it is an interesting dilemma. It is telling us that there is not necessarily a problem in attracting people there. We are getting very conflicting evidence.

Ms Mohle—Certainly in relation to Queensland, there has been a lot of work done through the Ministerial Taskforce, Nursing Recruitment and Retention, which is working with the universities in planning actual intakes. You might want to talk to Queensland Health and the principal nurse adviser, who I think is giving evidence after us. That has been successful in terms of working with the universities to ensure that we are getting the correct number of nurses coming out. Queensland has put a bit of work into that sort of area. There certainly are issues. We were advised again yesterday that there was a 10 per cent increase in the number of people who applied for nursing as their first preference this year in Queensland. I guess that there is a wastage rate with any undergraduate course.

Senator KNOWLES—Have you seen any evidence of the scores for entry dropping here?

Ms Hawksworth—Not recently. They are certainly different, depending on the university, but I have not seen any major drop.

Ms Mohle—Except for the anomaly with enrolled nurses. There is an interesting anomaly with the two-year TAFE diploma course for enrolled nurses. The entrance score for that is higher than for some registered nurse courses. They have worked out that—

Senator KNOWLES—I do not think we needed you to tell us that. That just further confuses it!

CHAIR—What have they worked out, Ms Mohle?

Ms Mohle—I think they have probably worked out that they can be employed as enrolled nurses and then upgrade to a registered nurse qualification while they are working. We have

been watching this over the last couple of years and, for Southbank TAFE—the one that is nearby here—it has been higher.

Senator KNOWLES—In relation to all of that, you have also got in your submission:

That allocation of student nursing places to universities be based on thorough workforce planning, the nursing needs of geographical areas and the ability to resource appropriate clinical placement not just on the potential for income creation for individual universities.

Are you saying that that is not being done adequately while also saying that an attempt has been made to achieve that type of outcome?

Ms Mohle—An attempt certainly has been made in Queensland, but we have a lot further to go. That would be our view.

Senator KNOWLES—Who should do what you are suggesting here, and in conjunction with whom?

Ms Mohle—The difficulty is, as you pointed out, Senator Knowles, that there are state and federal government responsibilities in this area. We met with the national nurse education review people last week and discussed this issue. We think that there is a need for a whole of government response to that at a Commonwealth level, and that a good starting point would be an equivalent to the principal nurse adviser position in Queensland, where you can look at nursing work force planning issues across the whole country. If you correct a problem in one state, it just creates flow-on effects if you do not address the issues in a cohesive way across the whole country. That is our view. There needs to be some sort of overarching national framework approach to this. The states and territories are implementing their own strategies but, with tertiary facilities, for instance, there certainly is a role for the federal government to be involved—and in relation to industrial relations, from our members' and the public sector's point of view.

Senator KNOWLES—I always get a bit nervous, when we ask a federal government of any colour to tell the states what to do and what is best for them. I happen to believe that the states on the local scene are far better to judge what is required in a situation such as you are describing here. It could be better state liaison with the universities.

Mrs Barry—I think it is more of a coordinated approach nationally—

Ms Mohle—A collaborative approach—

Mrs Barry—a collaborative approach, in terms of identifying what the work force needs are, but with some coordination nationally.

Senator KNOWLES—As long as the Commonwealth does not tell the states at the end what they need to do and how many nurses they need. Is that what you are saying?

Mrs Barry—I think there would have to be some type of recommendation or decision, but I would see it as a collaborative approach with the states and the Commonwealth.

Senator KNOWLES—I do not ever see that some bureaucrat sitting in an office in Canberra can tell me what is best for outback Western Australia or Far North Queensland or wherever. But anyway, I understand what you are saying.

Senator LEES—From evidence we have heard elsewhere, it is not so much the drop-out during university—it is when they hit the wards for the first time and start looking at 'Where am I going to go?' Have you got any figures on the attrition rate in Queensland after completion?

Mr Parle—In the survey that we have done—not the Queensland figures but the national figures from 6,800 responses from nurses—37 per cent often think of leaving within the first 12 months, which increases to 60 per cent at the three to five year mark and then starts to level off.

Senator LEES—We will go back to your data and have another look at that. I am interested in your recommendation 21:

... that the completion of an internship year should not be a requirement for nurse registration.

I am still looking at these new graduates and how we actually hang onto them in nursing. Are you arguing that there should not be an intern year or that they should be fully paid while they are doing an intern year?

Ms Mohle—They should be fully paid. The jury is still out in relation to preceptorship programs; isn't it, Kym?

Mrs Barry—Yes.

Ms Mohle—That would be where that would be coming from. Certainly, we have not seen any evidence that there are any better outcomes for either nurses or the system.

Senator LEES—If they do the year? That was one of the issues that was raised as a possible solution to the high attrition rate in those early years.

Mrs Barry—I think it is more about support in that first year as a new graduate, particularly in the public sector. It is all about support and the degree of support.

Senator LEES—How do we do that?

Mrs Barry—There are a number of models. You could ask Queensland Health what models they have put up. There is support and backfilling for those experienced registered nurses to support the new graduates, which is not happening at the moment. Again, it is probably more a state responsibility, but how do we provide the support to the new graduates in the clinical units to encourage them to stay on and become some of our experienced nurses?

Senator LEES—You have made some comments about unqualified people now in nursing, which has been raised elsewhere. Are there no rules and regulations here in Queensland that insist that people have a basic certificate of some sort before they are out in a nursing home or wherever?

Ms Hawksworth—No, there is not. Certainly some in aged care would have a certificate III. Interestingly enough, over the last six months we have had complaints from our assistant in nursing members who are unlicensed about the level that is now coming in below them in aged care where they have no qualifications or experience whatsoever.

Senator LEES—Is there an age restriction? Are they at least 18?

Ms Hawksworth—No. They could be juniors; they could be younger than that.

CHAIR—What are they called?

Ms Hawksworth—They are called a variety of titles.

Senator LEES—Officially?

Ms Hawksworth—We cover assistants in nursing under the Queensland Nurses Union awards. And experienced assistants in nursing, who in fact may or may not have a certificate III or IV, are telling us that now, because of the shortages in aged care, people are being employed—they commonly call them 'people off the street'—who have absolutely no experience whatsoever in working with elderly people. What has changed the situation is ageing in place. Where you had a distinct delineation between a hostel and a nursing home once upon a time, we would have covered the members employed in nursing homes—that would have been registered nurses, enrolled nurses and assistants in nursing. With ageing in place we now have high-care residents in low-care facilities—the old hostels. They are covered in Queensland depending on where they are geographically because there are demarks with the Australian Workers Union and the Miscellaneous Workers Union in terms of who covers them. So they can be personal care assistants, personal care workers, aged care workers.

Ms Richards—Hostesses.

Ms Hawksworth—Yes. There are a variety of titles. What is certainly becoming a problem in that area is the number of high-care residents who are in what were traditionally low-care facilities or hostels.

Senator LEES—I read the Adelaide *Advertiser* on the plane this morning. The front page story states that midwives cannot finish their courses in Adelaide because no-one is prepared to insure them while they are on the wards getting their practical experience. So, isn't insurance an issue out there for people who have absolutely no qualifications and might not even be 18? Who is covering them for insurance?

Ms Mohle—I do not know about insurance. Certainly, from a regulatory point of view, we have made submissions over a number of years to the Queensland Nursing Council that such workers who are performing nursing work need to be appropriately regulated. Our most recent submission, to a national competition policy review that has just been undertaken of the Nursing Act in Queensland, says exactly that: that if these people are performing nursing work, they need to be regulated by the nurses regulatory authority—because if they are not you just cannot guarantee standards of care.

Ms Hawksworth—The other point in that is the administration of medications. There are carers provisions in Queensland, under the drugs and poisons regulations, which go to providing advice as to what should happen with people assisting. Essentially what it means is that an elderly person has to ask for assistance from the carer to help with their medication. That means they have to be fully functioning and know the drugs they are taking. Virtually every day of the week we hear of unqualified carers administering medications in aged care facilities. That is happening more and more and is a major problem, we believe. In terms of insurance, the Queensland Nurses Union provides, for its membership, professional indemnity insurance—apart from home birth midwives. All other midwives are certainly covered by our insurance except for home birth midwives.

Senator LEES—That is what I was looking for. These people are certainly not with you, in terms of their insurance?

Ms Hawksworth—No, a lot of them would not be. A lot of them would be covered by the Australian Workers Union or the Miscellaneous Workers Union or are not members at all, so they certainly would not have insurance.

Senator WEST—Can I continue this conversation about aged care. Can you tell me or give me any indication what the representation of RNs and Ens, and maybe even AINs, is in the community aged care packages, those packages of nursing that are being delivered in the community to keep people out of nursing homes and hostels? What is your information about those?

Ms Mohle—It is an emerging area. There would be registered nurses who would be involved in coordinating and planning the care but they would be a much smaller number than unregulated workers working in that area. We would not have any detailed information. Certainly it would not be up to date because information from registering authorities, for example in terms of where people are working, is a couple of years behind. I think we have got up to 1999 data. Because a lot of the CAPs have recently been expanded, we would not have recent data—other than anecdotal information that nurses may be employed to actually coordinate the care, though not necessarily, and there would be a very small number of enrolled nurses or assistants in nursing. They would be 'other forms of carers' predominantly.

Senator WEST—Do you see this as an area where you could in fact get even greater deregulation occurring and more off-the-street people with no formal qualifications?

Ms Mohle—Certainly. That is one of the reasons behind our recommendation to the national competition policy review of the Nursing Act—that we really need to look carefully at getting a definition of what is nursing practice and then regulating that practice to ensure that only people who are appropriately qualified can actually perform nursing work.

Senator WEST—I suppose I should have fessed up in the beginning to say I actually am an RN with membership of the two colleges. Mr Parle, how long have you been conducting these surveys?

Mr Parle—These particular surveys—since late 2000.

Senator WEST—So you have no benchmark by which to measure them in terms of nurses' satisfaction with the profession in, say, the last 10, 20, 30 or even 40 years?

Mr Parle—We have been doing hospital-wide surveys in the health sector since 1995, including nursing and non-nursing. These particular ones that we started in late 2000 are focused on nursing. In my view, there has not been a lot of change on the issues of satisfaction, morale and leadership and those sorts of things. There are good ones and bad ones, and the mean seems to stay about the same.

Senator WEST—As I was reading some of your findings I was thinking: 'So what has changed in 30 years?' I was not sure that a great deal had changed. Can I go to some of your findings because, from a very quick and crude reading of quantifying the risk, it seems to be very hospital oriented.

Mr Parle—The ones so far?

Senator WEST—Yes.

Mr Parle—You will notice there a list of the 50 benchmarking partners to date.

Senator WEST—Where are the 50? I do not have that material.

Mr Parle—There are actually five separate inside sections. You have probably received photocopies of the inside sections. I am happy to leave the list with you. In Queensland, we have the Greenslopes Private Hospital, the Mater Children's Hospital, the New Farm Clinic, the Princess Alexandra Hospital, the Roma Health Service District, St Andrew's War Memorial Hospital, the Wesley Hospital and St Luke's Nursing Service. There is a range, but very heavily oriented towards acute.

Senator WEST—Hospital , yes. So you do not think you might find that, if you were to survey other specific areas of expertise and work, you might actually get variations within the different practice areas?

Mr Parle—Within the health sector?

Senator WEST—Yes.

Mr Parle—We have done some with community and aged care and some of the public health districts, and we end up rolling those in as well. We are not finding large differences in the risk factors that are not generated by other factors—for example, locality. So there is a difference between metro and regional in the risk factors. The risk factors of nurses wanting to leave the profession or their organisation are lower in the regions. When they talk about that, it is to do with lack of options. When we look at those sorts of issues, they pretty well explain the differences we are seeing between acute and aged care and community at the moment. As the process evolves—and there are another two dozen in train at the moment—we should get to a better mass of data so that we can pick up on those sorts of issues if they exist.

Senator WEST—I think they exist, but I cannot prove it.

Mr Parle—I cannot yet either.

Senator WEST—That is why I am interested. This seemed to me to be very skewed towards hospital/acute care, and I wondered how relevant that made it. I do not know whether you have any from Western Australia?

Mr Parle—The only one from Western Australia is Hollywood.

Senator WEST—Which is what?

Mr Parle—A large private hospital. It used to be a Commonwealth repat hospital; it is now in the private sector.

Senator WEST—Is there also not a weighting towards the private sector in your study?

Mr Parle—Yes, that is where it started. Our client base originally was drawn very heavily out of the private sector, and it was our clients who wanted to be involved in it. It is now extending into more public sector organisations, and our aim is to increase the percentages not only in the regions but also in the large metro hospitals, because they have entirely different issues.

Senator WEST—Getting back to the Nurses Union, are your members who are situated along the border with New South Wales saying that there are differences between the states? Do you have nurses who are resident in Queensland going across the border into New South Wales to work because there are better conditions there—or vice versa?

Ms Hawksworth—There are certainly some who work both in Queensland and in New South Wales, and we have had to come to an arrangement with the New South Wales Nurses Association about coverage for those members who actually work in both states. There are large hospitals on the Gold Coast—for example the Gold Coast Hospital and the John Flynn Hospital, a private hospital, and a number of other private hospitals. There are not as many hospitals on the other side of the border as there are on the Queensland side, because the Gold Coast is a major area. In Tweed Heads there is a private hospital and a public hospital, and that is about it. The majority of nursing work around the border would be in Queensland.

Senator WEST—How much of a problem is the border in terms of registration and different practices?

Ms Hawksworth—Nurses will tell you that they want national registration because they are a fairly mobile population. It comes up constantly and it comes up at our conference. For example, the issue that comes up from our membership is that the QNU should lobby for national registration, because people tend to work across the states a fair bit. But, with mutual recognition, it is not a problem in registering in other states. It seems to be an issue for nurses, yes.

Senator WEST—If one state gets out of kilter with another state in terms of salaries, income, do you notice—

Ms Hawksworth—We certainly noticed a move back to Victoria towards the end of 2000 and through 2001. That was based on our membership figures. There was a big increase in the number of interstate transfers because we are affiliated with the Australian Nursing Federation in all the other states. Our members do not resign; they transfer, so they need to let us know when they want to transfer. We did notice, on our figures, that there was a trend back to Victoria after their staff-to-patient ratios came in at the end of 2000 and the early part of last year.

Senator WEST—So there is a need for some close cooperation between all the states and presumably the federal government to ensure there is a degree of commonality to stop the flow, the moving around the country.

Mrs Barry—Just to maintain the consistency.

Ms Mohle—From our point of view, for a very short period of time in the early nineties we had nationally consistent rates of pay, with the exception of New South Wales because they are always different. But, with all the other states and territories, we had consistent rates of pay. It was just for a very short period of time, and then along came enterprise bargaining and now everything is totally out of kilter. We have always had concerns about enterprise bargaining. We maintain that it is not good for our members and for the health system to have that level of disparity across the country or even within our state.

Ms Hawksworth—I will give an example of that in the state. The private hospitals—and I have talked to nurses and employers in the private sector—are also having difficulty with recruitment. Some of the big private hospitals pay at around the same level as the public sector, but not quite, so they pay less than the public sector. Greenslopes Private Hospital and New Farm Clinic—or Ramsays—paid their next certified agreement wage increase in early January. It was due on 1 July but they brought it on early in an attempt to recruit nurses and retain them because their wages had jumped up by that amount in six months. I have never seen that before.

Senator McLUCAS—I wish to come back to the issue of the difference between regional and rural shortages—and you make the comment in your submission that Queensland is different because so much of our population is not in the capital city. I acknowledge the point you made, Mr Parle, about retention being higher—I think you were saying—in rural areas because of lack of options.

Mr Parle—The risk of them wanting to leave is lower because of their perceived lack of options.

Senator McLUCAS—Do you have any data on the difference between regional and rural shortages?

Ms Hawksworth—Mount Isa would certainly be a significant area in Queensland, and Queensland Health has attempted to do something about that by offering only to registered nurses in Mount Isa what is called the Mount Isa allowance of $120 per fortnight. That is not paid to anyone else, just registered nurses in Mount Isa in an attempt to keep them working at

the Mount Isa Hospital. Queensland Health would have more figures on this than we do, but there is a significant number of positions that are filled by agency staff at Mount Isa. It is a big hospital—they do surgery and so forth—so it is certainly an area in the state that is a major problem area.

CHAIR—Are the nurses who are encouraged to stay in Mount Isa with $120 a fortnight—

Ms Hawksworth—That is $120 a fortnight extra.

CHAIR—provided with accommodation?

Ms Hawksworth—There is some accommodation, but it is not particularly good accommodation.

CHAIR—What sort of accommodation is it? Is it shared housing?

Ms Hawksworth—No, it is not shared housing; it is nurses quarters.

CHAIR—It is an old nurses home: a smallish cell and down a corridor from the bathroom.

Ms Hawksworth—It is one of the reasons they have kept nurses quarters in some of the country areas, as opposed to getting rid of them, because it is sometimes the only way to be able to attract them. Rental accommodation is very expensive in Mount Isa.

CHAIR—If you had a husband and three children, could you get a room in the nurses home?

Ms Hawksworth—That would be quite difficult. It is one of the major problems in the provision of housing to nurses. You will often find that a single doctor will have a house, but a married nurse with a family might have a duplex. So there are some inconsistencies in how the housing is allocated.

CHAIR—According to some of the evidence we have been given, those nurses who have duplexes are well ahead of the game, because a lot of others are asked to share a room.

Ms Hawksworth—Yes, that is right. They have made some significant changes. Queensland Health has attempted to address that—certainly in some of the remote areas—over the last few years, but there are still some problem areas.

Senator McLUCAS—I am interested to know if you have any data on the continuity of service in rural areas, as opposed to city areas. Is there any data on people staying in those positions for longer periods?

Mrs Barry—No, we do not have any data on that.

Senator McLUCAS—I will talk to Queensland Health; they might have some.

CHAIR—I ask about the waiving of HECS, particularly for postgraduate situations. I am interested to know why you are proposing to waive HECS rather than introduce it, when a lot of the evidence given to us said a lot of people have to pay up-front fees to do postgraduate courses and would dearly love a HECS opportunity so they did not have to find the fees up front. Certainly, they would have to pay it off when they went back into paid work. Scholarships would be even better. Can you comment on whether any of your members have said they would rather have HECS than pay up front for postgraduate nursing courses?

Ms Mohle—There is the PELS scheme—a HECS like arrangement—for postgraduate courses. Our point is that, whether it is PELS or HECS, there should not be any form of fees until such time as the shortages are addressed and we have an appropriate work force balance in terms of the needs of the health system. It has been significant that nurses have paid $35,000 in opportunity costs and the like. I am sure they would have preferred to have had the ability to pay it off, but our view is that it is in such a crisis situation that it requires some desperate means in terms of support.

Ms Hawksworth—In those terms, you can look at midwifery in particular. You cannot practise midwifery without doing the course and being endorsed as a midwife. There is certainly a midwifery shortage. We see that in the regional and rural areas in Queensland, where nurses who do have midwifery are doing long hours on call because they are the only midwife in town. That is something that could be looked at for midwifery, because that is the one area of speciality that you cannot practise without doing the course and being endorsed to practise.

CHAIR—With regard to best practice, what stage is the benchmarking study at? How much longer do you think it has to run?

Mr Parle—I have surveyed over 11,000 and have 6,800 responses. The study will run as long as organisations require the data to help them manage. We have just started on the second cycle, so the first hospital that did it—the Princess Alexandra Hospital—is now doing it again to see where their areas of improvement are and to set up their strategies for the next year. We will keep doing it for as long as people find the need for it.

CHAIR—Do you have any further information, added to what you have submitted, that you could provide to the committee?

Mr Parle—There is another insight that we will be issuing very shortly that looks at 26 attributes in organisations that tend to correlate with lower risks of nurses wanting to leave the profession.

CHAIR—Would you be able to provide that to the committee in the next month?

Mr Parle—We can provide that in the next day—it is coming out very shortly.

CHAIR—Thank you very much. Can you tell us a bit more about the study's finding that 67 per cent of the risk of nurses leaving cannot be controlled at the organisational level and requires structural change on an industry-wide basis? What sorts of things are you picking up there?

Mr Parle—That came out of one of the interim findings about six or eight months ago. Basically, we are trying to separate out the professional issues from the organisational issues. We are finding that the organisational issues tend to mask what is going on professionally. So a lot of the issues that will come up professionally as triggers to leave the profession or triggers to leave the organisation are just that—they are triggers; they are not actually root causes. We are finding that organisations that can address some of the organisational issues first reduce the impact of those types of triggers. Whilst there will always be issues to do with pay, workload, shifts and so forth, where the organisational dynamics are not being managed particularly well, then those triggers become much more lethal—they become much more prominent in people's minds. The issue of separating out professional and organisational is part of what the process is about.

Clearly, there is a very strong correlation between the type of culture in organisations and the lower risk of nurses wanting to leave. There is a very tight correlation between social cohesion—liking the people that you work with, belonging to a community, belonging to that organisation—and lower risks. That is contained in the insights that you have already received.

CHAIR—So that is organisational rather than professional?

Mr Parle—Yes. We are finding that the correlation is not as strong with professional in terms of those cultural issues, but the thing is to get through the organisational mask, as it were, to work out what the real professional issues that are happening here are. People become much more resentful, much more sensitive to them, when the organisations are not being run particularly well.

CHAIR—Why get through the organisational issues to professional if the organisational issues are the problem?

Mr Parle—I am not saying that they are the entire problem.

CHAIR—Please explain further. What are the professional issues? Do you mean pay and conditions?

Mr Parle—Pay comes up as a major trigger to leave. This is contained in the submission: 50 per cent of respondents will talk about pay and responsibility as a trigger to leave nursing, 36 per cent go to workload and lack of staff—those sorts of issues. But we find that the effect of them is not as great in organisations that have got stronger and more energetic, motivated types of cultures or where they have got stronger levels of social cohesion amongst the nurses and the nurse managers. From our point of view, a lot of our advice comes back to the quality and style of leadership in the organisation. When it is being run well, the risk of nurses wanting to leave either the organisation or the profession drops significantly.

CHAIR—I have a question for QNU: have you looked at Best Practice Australia's reports?

Ms Hawksworth—Not in any great detail but we have had a meeting on the summaries with Mr Parle. We have done our own research.

CHAIR—Are the two in sync or has Best Practice produced something that is different from yours?

Ms Hawksworth—No, they are pretty much in sync. With respect to our research, we are happy to provide it to you on a confidential basis because it has not been released yet; we have some significant matters coming up this year and we may well need to use it in other forums, but we are happy to provide it to the Senate inquiry on a confidential basis. Essentially, what Mr Parle has said fits with what we have found. That research was conducted across the public sector, private hospitals and aged care.

CHAIR—Thank you, we would appreciate that. That is very helpful. Agency nurses in this state: how much does an agency nurse cost and what percentage of that cost does the nurse get?

Ms Hawksworth—We haven't got that figure from the agency, but on the 1,200 that Queensland Health used across the week that I spoke about before—

Ms Mohle—Assuming that half are agency nurses we have done a rough calculation that that would cost Queensland Health about $62 million—

Ms Hawksworth—Over a year—if that was the usage over a year.

Ms Mohle—Queensland Health might be able to answer that question.

CHAIR—We will check that out. It is just that we were told in Western Australia that nurses were leaving WA in block packages to go to Victoria, where the agencies were charging $200 to $250 an hour and keeping 55 per cent of that fee. We were told, I believe, in Sydney that the agencies were charging about a 20 per cent mark-up. So it would be interesting to get some figures in Queensland.

Mrs Barry—We have not got those figures. But certainly in Queensland, too, there are a number of agencies that now are charging a higher hourly rate for those nurses that are utilised in critical care areas such as intensive care. We have agencies in Brisbane, for example, that have a host of nurses on their books. If they are booked to work in intensive care—for example, at the PA—the hourly rate will be much higher than for the nurse from the same agency who would work in the ward next door to intensive care at the PA.

CHAIR—Yes, but how much more is the nurse from the agency being paid to work in intensive care than the nurse employed to work in intensive care?

Mrs Barry—I haven't got those figures.

CHAIR—We have been told that one of the reasons a lot of nurses are leaving is that in their first year out as an RN they may find themselves required to be the de facto head of ward—whatever clever words are used in Queensland, please tell me—because the other people working there may be agency people who have more experience but who are not permanent and there may be other part-time staff. So the recent graduate gets to be head honcho, and that is one of the things that puts pressure on them. You are all nodding.

Ms Hawksworth—Yes, we have certainly had calls from new graduate nurses. They have called—on duty—having found they are in this situation. They have been absolutely terrified. We have had to intervene with the nurse manager or the director of nursing and they have sorted out the problem at that level for us. They are absolutely petrified of being left in that situation.

CHAIR—We have also had evidence—and I think probably Mr Parle has touched on it—that wages are certainly one of the challenges, particularly the fact that there is no financial recognition for postgraduate qualifications in many cases. Wages are regularly given to us as a reason why nurses will leave. Yet there are lots of wage differences that you have just highlighted for us, particularly between private nursing and public. They are earning less in the private sector, and I understand the private sector has a shortage. How are the private hospitals coping when they have this added challenge of a wage differential working against them?

Ms Hawksworth—They are only coping at the moment—and they quite freely admit this, and have done to me—because they have nurses from the public sector who will work in the private sector as well. So they may be part time or they may be full time in the public sector but they would also be doing shifts in the private hospitals. I doubt extremely that any intensive care unit in a private hospital in Brisbane would be able to operate or function without nurses from the public sector working there on their days off or doing other shifts or certainly without a high percentage of agencies to fill in the gaps.

CHAIR—Are you able to provide us with any hard, documented evidence of that?

Ms Hawksworth—No, it is very difficult to get. You cannot get any data from the private sector at all. It is one of the major problems in getting a true picture of what is happening. It is just impossible—certainly for us—to get that information. It might be possible for government to get it—

Ms Mohle—It is even difficult for government.

Ms Hawksworth—It is certainly not possible for us.

CHAIR—But you do get a lot of anecdotal evidence?

Ms Hawksworth—Yes. It has certainly been said to me that that is the case.

Mr Parle—May I add something to that about the difference between private and public. When we analyse the attraction factors of why work in public versus work in private, they are quite different. Of nurses who want to work in the public sector, a lot of them are drawn by the experience and the professional development. But not so in the private; it is more to do with the hours, the greater flexibility of the hours, and interestingly enough the attitude of the staff—the belief that it is more friendly. They are actually differentiating between private and public and where they would want to work on that basis.

Senator WEST—QNU, I presume you are like the other nurses associations in that you provide legal support and representation for your members.

Ms Hawksworth—Correct.

Senator WEST—Have you seen an increase in nurses facing litigation charges in recent times?

Ms Hawksworth—Yes.

Senator WEST—To what extent?

Ms Hawksworth—To the extent that we employed our own in-house legal officer last year, who is a practising solicitor, because of the increase in representing nurses either before the Queensland Nursing Council or for coroners inquests. Nurses having to appear before coroners inquests has been one area where there has certainly been an increase over the last couple of years.

Senator WEST—What is the reason for the increase in the number of coroners inquests?

Ms Hawksworth—I do not know.

Senator WEST—Are the coroners doing more inquests?

Ms Hawksworth—I am not sure, but it has certainly been a factor over the last couple of years. I am not quite sure of the reason for that. It is a fairly regular occurrence now.

Mr Parle—Risk of litigation comes up as one of the top 25 reasons or top 25 triggers why nurses would want to leave the profession, but it still only rates as one per cent of them referring to risk of litigation or legal action as a trigger to leave.

CHAIR—We have to finish now. Could you take on notice to provide some evidence for us about numbers in terms of latex, skin penetration injuries and gluteraldehyde. They are very interesting points that you raised under the OH&S area. I do not mean a thesis but any numbers of how many skin penetration injuries—whether they are needle or other things such as cuts from scalpels, shards or broken things—and also the gluteraldehyde and the latex numbers. Also, is there anybody taking any notice of the numbers—are they sufficient to cause a significant change in policy et cetera? Thank you once again for your contribution, your submission and attending today.

[10.05 a.m.]

NORRIE, Ms Susan Anne, Principal Nursing Adviser, Queensland Health

WALLACE, Ms Gloria Jean, State Manager, Organisational Development, Queensland Health

CHAIR—The committee prefers all evidence to be given in public but should you wish to give your evidence in camera you can ask to do so and the committee will give consideration to your request. Evidence given to the committee is protected by parliamentary privilege. Any false or misleading evidence given to the committee may constitute a contempt of the Senate. Also, particularly in your position, you are not required to answer questions on the advice you may have given in the formulation of policy or to express a personal opinion on matters of policy.

The committee has before it your submission No. 942. Do you wish to make any alterations to the submission?

Ms Norrie—No.

Ms Wallace—I think we would probably just like to expand on some points.

CHAIR—Okay. In that case I ask you to make an opening statement and then field questions.

Ms Wallace—Queensland Health would particularly like to inform the committee about the work it is doing in relation to work force management. Health work force planning and management are emerging as critical issues nationally and internationally. Queensland Health established a work force planning database in 1995, which now provides us with about eight years of data. This data allows Queensland Health to monitor trends such as turnover and return rates, work force age et cetera. I need to add that it probably does not do everything that we would like it to but we have some data to work with, which gives us an advantage over some states.

This data shows a reduction of state average turnover rates in nursing from 20 per cent to 15 per cent since a number of strategies have been put in place under the auspices of the Ministerial Taskforce, Nursing Recruitment and Retention. Ms Norrie will enlarge on the task force activities in her opening remarks. Our work force data also shows that, similarly to most states in Australia, the average nurse is aged around 42 years. We have some concerns that the shrinkage of the general recruitment pool due to predicted Australian population patterns over the next 10 to 20 years will have significant future impacts on recruitment to health professions. The health professions will be competing more vigorously to ensure that their share of the recruitment market enters into undergraduate programs. For nursing this might be particularly significant, due to issues such as unsociable hours and physically demanding work having the potential to reduce interest in the profession.

Health care is changing rapidly. Models of care emerging over the past 10 years would not have been considered possible 20 years ago. This has to be taken into account when planning the health work force of the future. We are pleased to be participating in recent national initiatives and believe that national work force planning approaches are imperative. Queensland Health is committed to the development of a work force planning methodology that, rather than addressing professional groups in isolation, plans work force requirements around streams of care. Queensland Health has commenced planning processes for aged care and oncology services, using a scenario planning approach that identifies demographic factors that impact on the stream of care—for example population ageing, population migration et cetera—and identifies anticipated changes in technology and treatment patterns which have the potential to impact on the way that care is delivered and those who deliver it. For example, in aged populations there is an increase in radiotherapy treatment approaches in some cancers. We use these factors to assist in the development of the most likely service delivery scenarios for the future, and then the intent is to plan likely work force requirements based on those scenarios. It is a new approach to planning which has the potential to take into account things like shifting professional boundaries and changing roles. Queensland Health is attempting to undertake its planning in a collaborative way, with key stakeholders attending our scenario planning workshops.

We are trying to improve our people management through the development of a people plan, which is really an overarching philosophy concerning the key goals and outcomes that need to be considered in the way people are managed in a contemporary work environment, and through the development and funding of the human resource management capacity and capability building project, which is aiming to improve the skill base of our HR managers and our HR systems management processes to ensure a more skilled and consistent approach to the management of our staff. In the area of improving work force management, Queensland Health has put in place a range of strategies specifically targeted at nurses through the recruitment and retention task force. Ms Norrie will address that in more detail.

Ms Norrie—Thank you very much for the opportunity to appear before the Senate inquiry and to give the views of Queensland Health. The matters addressed in the Senate inquiry are similar to those that were identified by the Queensland Ministerial Taskforce, Nursing Recruitment and Retention. This task force was commissioned in August 1998 by the Hon. Wendy Edmond, MLA, Minister for Health.

It has three terms of reference but basically it was reviewing work force issues and recruitment and retention of nurses in Queensland. The report with the 59 recommendations was launched in December 1999. Since then we have had a ministerial task force implementation committee representative of all key stakeholders, including the Queensland Nurses Union, the Queensland Nurses Council and the Queensland Nursing Academic Forum, progressing those recommendations.

I should acknowledge here that it is anticipated that the strategies being implemented by the task force will have medium- to long-term results. I will briefly summarise the key recommendations; I would be very happy at the end to elaborate on those. The major areas addressed were a career advisory service; a graduate recruitment online and the launching and development of a thinking nurse web site; the establishment and implementation of rural undergraduate scholarships; the implementation of a state-wide preceptor program; the

development and implementation of a business planning program; the establishment of an education standing committee to formalise communication between the universities and Queensland Health, which in the first round has looked at a policy and guidelines for the placement of our undergraduates and also mapping Queensland to see how many new graduates we can take, so that we are very clear about the numbers; the development of transitional education programs for both beginning and existing staff. They have already been developed in intensive care, high dependency, perioperative and medical surgical. At the moment, we are in the process of developing them in aged care, oncology, renal and neonatal.

The developments in line with the following recommendations are progressing. They are: the review of level 3, 4 and 5 of our nursing career structure. This has been done again with the Queensland Nurses Union; looking at the enrolled nurse advanced practice. We are also looking at a child-care review and the establishment of a remote and relief agency based on hub sites. As I said, I would be very happy to elaborate on any of these matters. Thank you.

Senator LEES—I would like to pick up where you finished on the remote relief agency. Is that a rotational or a roster system where nurses spend time out and some time back in a ward?

Ms Norrie—One of the recommendations from the task force was to look at secondments. As the implementation group went through this and we got the expertise from our rural areas, we realised it was not successful at all. In fact, we spent a lot of time looking at how we could do this and we acknowledge the difficulties of backfilling for families where a lot of the nurses within that rural environment were the sole breadwinners and they found it difficult to come in for secondments. This agency gives people the opportunity from an individual and organisational point of view. We have clearly set up the expectations. I have got the document here if you would like me to leave that.

Senator LEES—Yes, thank you.

Ms Norrie—It is looking at people who wish to be placed on the database. We have looked at the education required. One of the issues that we have had in the past has been that we have not prepared people as well, and we acknowledge that. It has been often in a reactive fashion. What we are doing is looking at what we believe needs to happen to gain that expertise, again from our rural areas. We are looking at an education support pattern and making sure that they are supported in those areas as well.

Senator LEES—What is the key to boosting nurse numbers in rural and regional Queensland? Are we looking at base issues like housing or are we looking at recruiting people from the country in the first place with perhaps some sort of state government support maybe for a scholarship scheme with some living allowances?

Ms Norrie—I think there are multiple factors involved—as has been noted by the previous speakers—and they are related to a true understanding of what it is like out in the rural environment. One factor is that people often believe it would be nice to go out there but they really do not appreciate what it is like because they have no background out there, or they do not have family support or peer support. There are also issues associated with accommodation and we have acknowledged those issues. Queensland Health has done an enormous amount within that area.

Senator LEES—What has Queensland Health actually done within that area?

Ms Norrie—The recent budget allocated $8 million for nursing and allied health accommodation in areas which have been identified as problematic. You have already heard about those areas: Mount Isa, other areas such as Gladstone, and the refurbishment at Cape. I do not know whether the committee realises that accommodation has been brought up before and there has been work done previously, so I believe this is an enhancement.

We are also looking at other things such as families. You have already commented on the fact that people take their spouses or their children and that young people today want the opportunity to bring their friends with them. Undergraduate scholarships and supporting people within the rural environment have assisted rural people to get into the nursing profession. It would appear that people now have a better understanding of what the environment is like that they are getting into and they have a tendency to go back into those areas.

Senator LEES—Do you offer any scholarships through the state government program? If so, how many?

Ms Norrie—Yes, we do. As a result of the task force, we have 15 undergraduate scholarships in the second and third year. We have four indigenous nursing scholarships which are allocated for the first, second and third years. We also have other support through Queensland Health and Gloria Wallace may like to comment on that; we have provided support in the mental health area; we have three $10,000 nursing scholarships, which nurses can apply for; and we also provide support for our new graduates going into rural areas by giving $3,000 per head.

CHAIR—$3,000?

Ms Norrie—$3,000 per head for each new graduate to provide support for their transition into rural areas.

CHAIR—Who is that paid to?

Ms Norrie—It is paid to the health service district that takes on those new graduates in those rural areas. It enables them to give some support for backfilling and to put on a staff member to support them for a short period of time. There have been many monetary strategies that we have put in place to assist in the process.

Senator KNOWLES—From where the Queensland government sits in the work force planning area, the union presented an interesting dilemma this morning: they are advocating that the federal government should look at the possibility of taking on all the work force planning, nursing requirements planning in geographical areas and planning for the ability to resource appropriate clinical placement. Were you here when they gave that evidence?

Ms Norrie—Yes.

Senator KNOWLES—So you know where I am coming from in that I always feel the states are the ones who know their own requirements best. How would you see a proposition such as the one the union promoted as working?

Ms Wallace—From my perspective, one of the key issues for us is having a national data set on the nursing work force that will enable us to actually plan for the future. There have been problems with the data that is currently being collected through the Australian Institute of Health and Welfare and it is being reviewed at the moment. There is a new survey methodology being designed and we have participated in that design. If we were able to obtain better planning data, that would enable the states to plan for local needs, but it would also enable us to get some planning across the country so that undergraduate entry numbers are consistent with what we believe are our predicted requirements—so I suppose it would be a safety net in the planning approach.

Senator KNOWLES—Could you tell me a little more about what your idea of that planning would be?

Ms Wallace—At the moment the data that has been collected does not give a clear view of how many nurses there are in Australia. I know that there are duplications in data if people are registered in a number of states. Just to have baseline data on which we could plan would be a good start. My view, and Queensland Health's view, is that we have to start planning in a much more multidisciplinary way rather than planning in isolation. I have looked around the world for multidisciplinary planning methodologies and, unfortunately, they simply do not exist. People have not approached health planning in that way anywhere at this point. We are trying to develop a methodology here that enables us to plan along streams of care. We are having a lot of difficulty doing that, but we want to persevere with it because we believe it is very important.

Senator LEES—So that is trained nurses? That is looking at how many nurses, how many doctors and allied health workers you need in a package?

Ms Wallace—Yes, and looking at the potential for changing the scope of practice into the future, the potential flexibility of that work force, and some of the boundary issues that are very difficult to deal with in the current environment.

Senator KNOWLES—What other useful contribution do you believe the federal government could play in helping you plan and in helping the work force problems that you have at the moment?

Ms Wallace—The recent move by AHMAC to establish the Australian health work force officials committees has been a great start, because the states and the Commonwealth are now meeting to identify what the priorities are for work force planning. The first priority that is being looked at is establishing some baseline as to what kind of planning is going on and doing an audit of what planning material is available across the country. The second one is targeting some of the areas that are seen as nationally problematic. The areas that have been proposed—I am not sure whether they have been accepted or not—are emergency departments, aged care and mental health.

Senator KNOWLES—On that point, Ms Norrie, you were talking about the areas of planning. I heard you talk about aged care, oncology and obstetrics, but I did not hear you mention mental health. Is mental health involved in that area as well?

Ms Norrie—Mental health was identified by the task force as a critical area. We looked at working very closely with our mental health branch and we initiated some mental health scholarships. We acknowledge that we have a lot more work to do in this area and that we are still having difficulty with people going on to specialise in mental health. I do not think it is any different from any other state. There are a lot of factors involved in why that is occurring.

We have not looked at a state-wide transition program. The reason is that we are absolutely pushed with what we are doing. We want to bed down what we have done and monitor and evaluate what we are doing and implement that across the state. One thing I did not mention is that these are state-wide programs. We are trying to maximise our expertise within larger organisations, to support rural areas. We are trying to look at champions in the set-up of this. We are getting an information database. These transition programs are very much valuing the clinical acumen. The clinicians within our organisations have said, 'We need to encourage people in here. We are best placed to look at the clinical competencies. We want to involve the staff, but we want articulation with our professional colleagues at the university.' So these transition programs are about allowing nurses different choices. Some, because of their family obligations, will choose not to do assessments. The aim is to stop nurses from having to jump over three or four different hurdles and for them to get credits and recognition for what they have done in a clinical setting, so that they can take that into the university—which nurses have been constructively critical about. We feel we have enough to do at the moment, but I acknowledge your comment about mental health.

Senator KNOWLES—One of the issues that has been raised with us wherever we have gone is that of unsociable working hours and rostering and other such things. I notice in your submission that you talk about the need for national research into the impact of unsociable working hours and variable shift length on the retention of nurses. Given that there are a whole lot of people who work pretty unsociable hours, in shift work and everything else, what are you doing to try and address that problem?

Ms Norrie—One of the things we noticed when we were setting up the careers advisory service was that undergraduates had very different perceptions of what nursing was about. Our Think Nursing web site talks about shift work and very much highlights this area. I am stating the obvious when I say that it is very important that people know what they are getting into. I know that might sound ludicrous, but even today we have people finalising their clinical placements who have not been exposed to shift work. That brings a whole gamut of associated problems with it. You are right that, with the way things are today with corner stores open 24 hours and the expectations that people have, unsociable hours are a difficult issue too. Part of the task force were looking at some rostering principles and developing some guidelines. We are working through those. We are working through some different shift configurations and we are trialling some different shifts in different organisations. One of the terms of reference was family friendliness, so we are looking at the opportunities for professional development, and we are looking at some of the other variables which impact. It is not just about unsociable hours but I believe it all factors in. That is the message we are getting.

Senator KNOWLES—That is interesting because we have also had the proposition of 12-hour shifts being put to us. I do not know if you have a view on that?

Ms Norrie—The nurses in our intensive care units wanted very much to trial the 12-hour shifts—

Senator LEES—We keep hearing about intensive care nurses being the ones that want to work 12 hours. I cannot imagine a worse place to do that.

Senator KNOWLES—I would have thought the stress of intensive care would—

Senator WEST—Yes, but you get a couple of extra days off.

Ms Norrie—We are undertaking it at Nambour Hospital. We have stringent evaluation of it. There were concerns about the pressure on nurses doing that, because of the complexity of the conditions of the patients they are caring for, but so far it has been received very favourably. There are things that we are looking at: incidents et cetera which they are monitoring. We have another six months to go, and a report will be written on this. I really cannot comment more than that, but there is no doubt that in some of the specialist areas the nurses are wanting these longer hours.

Senator LEES—We have come across this in other states and we find it interesting.

Senator KNOWLES—How serious is your problem with shortage in aged care?

Ms Norrie—It is serious. Registered nurses are finding the reporting relationships difficult, that is, with the unregulated carers. They are finding the documentation very arduous and very time consuming. There are some issues associated with that. I think it is related to the profile that aged care has. I do not believe we have the front end right in our undergraduate education of mainstreaming aged care right across the curriculum. In other words, we find our patients and our clients in our aged care, in our medical/surgical environment, in our community environment and in our ambulatory care, yet we are constantly stereotyping it as within our acute care, high-needs residential care and our hostels—I keep wanting to say nursing homes—in those areas. There is a stereotyping; that is what it's all about. If we look at that type of patient care with dementia and the co-morbidities, our registered nurses are finding that they need a very high level of skill, from a communication perspective with their patients and clients, and a very high knowledge level with the pharmokinetics and just the ability to care for those patients. It requires a very experienced registered nurse—and I am saying the absolute obvious.

Senator KNOWLES—Is the Queensland government doing enough to try to attract younger people into aged care, given the fact that it is not the sort of thing that is seen on TV at half-past eight at night on commercial television? It is not the thing that is perceived to be the fun place to be, yet it is so important.

Ms Norrie—One of the reasons for setting up the education standing committee and formalising the communication was to discuss and debate among the nursing profession just some of these issues. Often a lot of things are discussed outside the nursing profession without the profession being very proactive and setting up the recommendations. Aged care is an area in which the clinicians in the workplace have highlighted to me that the undergraduates come to in their first year or in the second year—which means that they do not believe it has, for want of a better word, a status associated with it. We are very much trying to work in a collaborative

fashion around the table with our nurses involved with curriculum design. The transition program for aged care was highlighted as very critical within the task force. There are many recommendations associated with this area. We have put in a transition program which we are still developing. The clinicians are developing that.

CHAIR—Transition between where and where or from whom to whom?

Ms Norrie—The transition program is a program which clearly profiles what it is that the registered nurse or enrolled nurse does within that environment.

CHAIR—You mean transition from an EN to an RN?

Ms Norrie—No. It is a term that means getting people into the workplace. That is how we have used it. Transition means to familiarise them and to support them. It is very much about support. It is very much about identifying critical competencies, what education is required and then developing a package of education modules for people to work through so that they provide safe and competent practice within those environments. We are also trialling a scheme supporting new graduates through this area in one district. They will be moving from medical/surgical into our high-care areas and our hostels. They will also work in dementia and community areas, trying to break down some of the barriers associated with caring for the aged.

CHAIR—I do not want to stop anyone and I do not want to stop your very useful info but I think we will have to have shorter answers and more questions.

Senator WEST—I want to continue that. Is this course just for new RNs, or is this also looking at getting those that have been out for a while back in—refreshers and re-entries? What are you doing there, or is this covering that as well?

Ms Norrie—We are just working through a re-entry and refresher program. As you are probably aware, in Queensland they go through the competence assessment. What we are looking at from Queensland Health is an initiative where re-entry will be paid as they undertake their competency assessment.

Senator WEST—Similar to New South Wales initiatives?

Ms Norrie—Yes.

Ms Wallace—Senator, let me just clarify it. The transition programs are aimed at either new staff entering areas or existing staff entering areas of specialty and it is giving them particular skills.

Senator WEST—What would you offer me? It is 25 years since I worked in a ward but I have worked in the community since then. What sorts of facilities and training are available to me to get back when I retire in June?

Ms Wallace—Are you still registered?

Senator WEST—I am still registered in the ACT.

Ms Norrie—In Queensland in respect of the competency assessment, there is an opportunity to do a challenge test to see what is required and there are four modules attached to that, so there is a program. Then what we would do is that there would be a preceptor and there would be support given by the Queensland Health staff.

Senator WEST—Is that only for those who want to go back to work into hospitals? What about those who might want to go back and work in the community or work in early childhood in the community?

Ms Norrie—We are actually working through that at the moment.

Senator WEST—So you do not have those back?

Ms Norrie—The opportunity is for them to be able to go to those areas. We would have to make sure that there was appropriate support and infrastructure. That is the feedback we are getting, and rightly so, that they need to be supported as well as undertaking programs.

Senator WEST—What support are you going to be providing for the preceptor? If they are going to be expected to continue their normal workload and on top of that do preceptoring, supporting, mentoring and the whole bit, that is a big ask. What structures have you got in place, or are you putting in place, to assist the preceptors?

Ms Norrie—It is a big ask and it is one of the major issues that is being addressed through the education standing committee. No. 1 is our policy and guidelines, and our work with that committee has highlighted the issues we are trying to look at. As you are probably aware, there are two types of models: the clinical facilitator model and a preceptor model. The preceptor model, when it is utilised by universities, and if it is Queensland Health staff, at the moment we are working through this with the universities in respect of payment if they are actually doing the assessments, which usually the university staff undertake.

We have actually put in training models and a framework and done a train the trainer around the state and put our preceptors through this and supported them. We have within each district a network for preceptors, but I do acknowledge what you are saying.

Senator WEST—You also said that there was a shrinking recruitment base as we baby boomers move on. Have any forward projections been done as to what are going to be the needs for new nurses coming online as the old ones drop off, and as we get an ageing population with all the attendant medical conditions and health and medical needs that are going to be flowing from that?

Ms Wallace—We have done those projections. I cannot tell you about them off the top of my head, but I can provide that data to you later.

Senator WEST—That would be lovely.

Ms Wallace—We have looked at the expansion that is going to be required in the health work force, and it is an expansion.

Senator WEST—It must be, because in the year, say, 2025, you are going to require a lot more staff from a smaller pool of recruits to look after that bulge of the baby boomers as they hit very senior old age.

Senator TCHEN—I would like to follow on Senator West's line. I notice in your executive summary in your submission that you refer to the ministerial task force report on recruitment and retention. You said it identified that the nursing work force in Queensland Health is ageing. That is nothing unusual. But you also said that the report also highlighted that 26 per cent of the registered nursing work force was aged 30 and below. Is that consistent with the other statement? Trying to read through the rest, there is no clarification on that. Is it a problem if a quarter of the work force is below age 30? You identify that as a problem.

Ms Wallace—That is not a problem. We would like to see more younger people in the work force. The issue for us, I suppose, is that prior to university based education for nurses, the work force was predominantly a very young work force. What has happened is that the work force has progressively aged, and often—

Senator TCHEN—New entry has to be over 20, usually?

Ms Wallace—Yes, and new entries to undergraduate programs are often mature age students.

Senator TCHEN—I see. You also said that the data collected for this task force indicated a majority of nurses obtained postgraduate qualifications before this age and that this might have implications for the supply of a future specialist nursing work force. Why is that?

Ms Norrie—In undertaking the postgraduate studies, we find that, if we have a smaller pool of people within that age group—that is, the years they actually undertake their postgraduate studies—that may be problematic. With the ageing work force, if we attract mature age students, there may be the likelihood that they may not want to undertake postgraduate studies.

Senator TCHEN—So your expectation is that only the younger entries tend to go on to higher qualifications?

Ms Wallace—That is what the data showed.

Ms Norrie—That is what that data showed then.

Senator TCHEN—In that case, I will go to a question I really want to ask. Senator West has asked you questions about mature aged qualified nurses re-entering the work force. Do you know of any study or strategy being developed to attract mature age nurses—not just those who are 26 years old or 27 years old but much older people—into your recruitment program? It seems to me, from what we have been told, that one of the biggest losses comes when graduate nurses enter the work force and have a reality check—a lot of them drop out then. It seems to me older people, whatever else, tend to be mentally tougher. Has any thought been given to re-

cruiting into the nursing profession not just the 26-year-olds or 27-year-olds as mature age entries, but people who really are older?

Ms Wallace—We have certainly not been specifically targeting recruitment of any age group. If we do not have the breakdown of undergraduate entries here—how many are mature age and how many are school leavers—we can give it to you later.

Senator LEES—That would be very helpful.

CHAIR—And data about what qualifies someone as mature age.

Senator TCHEN—I also wonder whether any thought has been given to actually encouraging the genuinely mature age entrants?

Ms Wallace—They are predominantly coming from that group at the moment.

Senator TCHEN—Which group?

Ms Wallace—From the mature age group.

Senator TCHEN—The 26-year-olds or the 46-year- olds?

Ms Norrie—I am happy to leave this information with you. As you said, our first preferences in all states have increased—the numbers coming in to undergraduate courses. Predominantly, we have been getting the numbers from the 25- to 40-year-old group.

Senator McLUCAS—I want to go back to the question of a regional and rural split. Do you have any data about the average age, the retention levels and the recruitment levels, separated for metropolitan, south-east corner, the coastal strip and then the west?

Ms Wallace—We can define our data by district. We can certainly define age by district. As I said, it is not a perfect database by any means, but we can define age by district. We can look at turnover by district and we can look at return rates by district. Our average turnover, as I said before, has reduced from 20 per cent to 15 per cent. However, that is a state average. There are still pockets of the state where it would be significantly more than that. The QNU mentioned Mount Isa and the Mount Isa allowance. Because it is the only hospital of its type that is doing specialised surgery and that sort of thing, it is very important to us to keep a specialised work force there—consequently, there has been the advent of the Mount Isa allowance to try to do that.

Senator WEST—Is it working?

Ms Wallace—It has not been going for long enough to know. It has really only been going for a few months, so we will evaluate it.

Senator McLUCAS—That was my question: has it been successful in actually getting RNs to stay in Mount Isa?

Ms Wallace—As I said, it is too early to tell.

Senator McLUCAS—You make the point very clearly in your submission that we do not know how many nurses there are in Australia. Are you suggesting that we need national registration or is there another way that we can find out how many nurses there are in Australia?

Ms Wallace—The Australian Institute of Health and Welfare, with the survey methodology that it is developing at the moment to which states have had an opportunity for input, is proposing a way in which we can get consolidated data nationally. There are issues around how you actually collect that data. For instance, at the moment the surveys are sent out on a state by state basis with the registration forms. It has been found that if you do not send them out with those forms, the return rates are much lower. So it is very important to us that we look at the methodology for actually sending out those forms and receiving them back.

CHAIR—Do you know whether the registration boards have any input into TAFE courses for ENs?

Ms Norrie—Yes, they do. Queensland Health has an enrolled nurse steering committee; the executive officer sits on that steering committee and there are representatives from TAFE. It would be best to ask them about this.

CHAIR—On page 10 of your submission there is a sentence that I would like your assistance with. At the bottom of the page there is a set of recommendations in bold. The third dot point reads:

> That there are articulation pathways for aged care nurses through industrial instruments and professional and industry groups.

I have read that often. I think it is grammatical, and I do not have the slightest idea what it means. Can you please help?

Ms Norrie—My understanding of that statement is that it is very much about the ability for nurses, no matter where—and we have used aged care there—to be able to do any sort of program, whether it be an enrolled nurse program or a certificate III program, and then to go through into an enrolled nurse course or a registered nurse course. They may not even start out; they may have done an aged care certificate, but the principle is there.

CHAIR—Senator Lees wants to pursue this line too.

Senator LEES—Looking at aged care, we have heard of unqualified people who basically come in 'off the street'—I think that was the terminology used—maybe not even 18 years of age, with absolutely no experience, and are left caring for elderly folk. I am not sure if there is anywhere else in the health system where people can simply come in off the street. Is that of concern to the Queensland government?

Ms Norrie—It is a concern if people are placed in a situation where safe and competent practice for our patients and clients is not there. Within our organisations, appropriate

orientation is part and parcel. With respect to nursing we have a scope of practice document which clearly talks about the accountability of the registered nurse and—

Senator LEES—But for the people you mention here in this sentence—'pathways' and 'professional groups'—do you have any requirements that these people must get some training pretty quickly and find their way along a pathway that will ensure they have at least got some sort of certification within a set period of time? Is it mandated that people should be trained?

Ms Wallace—I do not believe it is mandated, but the certificate III training is offered, and Queensland Health has supported people to do that training in the past. I would really have to look at the current picture to give you a full response.

Senator LEES—Please take that on notice; it differs from state to state. Just looking at a pathway, is there is an easy one where we can encourage people in to go up the line and move from enrolled on to registered as an option?

CHAIR—Do you know how many POTS—people off the street—there are?

Ms Wallace—I am sorry; I am really not aware of that and—

CHAIR—We have been told today that there is a grade of people less qualified than an AIN. An AIN could expect to have a certificate III. We have not heard about certificate IIs in Queensland, but we have in other places, and we were advised that there were people literally called 'people off the street'—no qualifications at all—who are now being brought into nursing homes to assist with the duties there. Do you know how many?

Ms Wallace—No. I suspect that is more likely to be happening in private nursing homes than in Queensland health facilities, but I would have to check. Queensland Health has mainly functioned on AINs.

Ms Norrie—We also have an advanced AIN as part of the task force. We have looked at enabling the AIN to multiskill.

CHAIR—I now understand the language of this. It is different language from other states, I am afraid, and I am doing my best to keep up with it. You are actually talking about nurses coming into the profession—EN or AIN moving to an EN, EN moving to an RN and maybe people moving off to different specialties—but if you do this, you should not be disadvantaged if you want to change your mind. That makes sense. And 'industrial instruments' means talking with the QNU about this being acceptable. Is that what an industrial instrument is?

Ms Norrie—That is part and parcel of it, but it is probably a bit broader than that—the awards and so on.

CHAIR—Okay. Do you not know too much about what is going on in private nursing homes?

Ms Wallace—No, not in our area of the department. There would be areas of the department where the licensing and those issues are managed and that could give us information.

CHAIR—Do you tick-tack with the Commonwealth about the numbers there?

Ms Wallace—In private nursing homes? No.

CHAIR—I am just a bit surprised. You are pretty unaware of the size of the problem of nursing qualifications in nursing homes—or whatever they are called now.

Ms Norrie—No, I am certainly very much aware, but I could not drill down and tell you how many people had not undertaken certain qualifications in the private sector. Through my reading and through my talking with my professional colleagues—

CHAIR—But I presume that, if you are looking at a national database to have some handle on the number of nurses needed, that would include the nurses needed in aged care facilities.

Ms Wallace—Yes. I think that is one of the issues that is very difficult in terms of overall work force planning. We can get the data for public facilities, but it is very difficult for us to get private facilities work force data, be they private hospitals or nursing homes.

CHAIR—Which probably makes your challenge very sticky indeed. Are nurse practitioners being promoted or are they already in existence in Queensland?

Ms Norrie—There was $100,000 allocated, again in the policy document, to investigate suitable models for nurse practitioner. We are in the process of working through that. But, in saying that, Queensland Health has undertaken, through our primary clinical care manual and isolated practice, endorsement of changes to the health drugs and poisons regulation, which would allow our nurses to supply and administer medications under certain drug therapy protocols, in line with an overarching health management protocol. They undertake education on that. In our remote areas we started that, because we were aware that we needed to legitimise practice that was already taking place. We had to make those changes to our regulation and put in an education program.

CHAIR—Are the nurses prescribing and administering or only administering?

Ms Norrie—We do not use the word ‘prescribe’; we use the words ‘supply and administer’.

CHAIR—What does ‘supply’ mean?

Ms Norrie—Give, on a prescription.

Senator LEES—So they do not write a script to take to the pharmacist; they have a supply of medications themselves?

Ms Norrie—Yes.

Senator LEES—What about referring for pathology?

Ms Norrie—Just to clarify that, the drug therapy protocols quite clearly talk about the approved route of administration. So these are the documents that guide the nurse in supply and administration.

CHAIR—One of the things we have learnt—and, again, this may be a challenge for you in terms of proper areas of coverage of responsibility; and you can tell me about Queensland, if you could, please—under the state legislation in other states there are restrictions for a lot of people in nursing homes on who can give what sorts of medications, but there are no restrictions in the law on AINs or even POTS. So in some situations those people are being encouraged—actually asked—to administer medications. Do you know of this in Queensland?

Ms Norrie—Again, I do not have an in-depth knowledge of that area; I have to be honest.

CHAIR—Have you heard a whisper?

Ms Wallace—I have not heard of it.

Ms Norrie—No. There is concern with the carers' provision and some of the issues associated with that. Yes, I have heard comments that are made with respect to medication management. But they are just feedback to me.

CHAIR—It is interesting, in terms of your proposing to assist the practice of medications and the administration of them for rural and remote nurses, that that has not covered the practice of administration of medications within the nursing home area or aged care area. Was it discussed at the time?

Ms Norrie—No. We are only implementing it just at the moment in the rural areas. It was for our remote locations.

CHAIR—Is there a restriction under Queensland legislation on who shall administer certain medications under your poisons act?

Ms Norrie—The poisons act is fairly clear about the role of the registered nurse and the enrolled nurse, yes.

CHAIR—But it is silent about non-qualified people?

Ms Norrie—Again I would have to go through the document to actually see.

CHAIR—It could be interesting. We have discovered in other places that the law is silent about people who are called AINs or personal care people—and goodness knows what they would say about POTS. But I think it has been suggested that other places are looking at amending the law to make it clear that those people are not eligible to administer medications, but this may cause a major problem when they may be the only people available. If you could provide us with any information about your legislation that would be useful. We have received

mixed responses about the national curriculum framework. Some people are very strongly in favour of a national curriculum or a national curriculum framework—preferably the framework—and others are dragging the chain on that idea. Your submission seems to be advocating national consistency in EN education. How would that fit with a kind of national involvement? Would you need a national curriculum if you are talking about a national consistency? How is it different?

Ms Norrie—With the qualification for ENs, it is all over the place. Queensland has a diploma qualification.

CHAIR—Which is 12 months?

Ms Norrie—It is 18 months. Queensland has endorsement of medications, which is part and parcel of that curriculum. With other states there are varying qualifications. Some states, with respect to enrolled nurses, have not had the training taking place and now are coming back into the training. So we believe that, from Queensland's perspective, there needs to be a focus on enrolled nurses and that there needs to be some similarities with respect to qualification.

CHAIR—So your national consistency is pretty close to national curriculum framework?

Ms Norrie—No, I do not believe I am saying that. I believe I am saying that there is a need for some standards—perhaps I have not expressed myself very well—and, for the practices of enrolled nurses, there is a need for us to be very clear about the outcomes, particularly with medication endorsement et cetera.

CHAIR—You indicate that there is a need for a significant increase in preregistration commencements, which I understand means starting off to be an RN?

Ms Norrie—That is correct.

CHAIR—You want that to dramatically rise from 1200 to 1700. Is that as well as everything you will do to retain them and to encourage their re-entry? Is that on top of that?

Ms Norrie—Yes, it is.

CHAIR—So that means you have a major shortage; currently there is a shortage and it is anticipated that, if you do not get these figures, it will get worse and worse very quickly.

Ms Norrie—No. Again from looking at our work force planning, those people coming into the nursing profession are our feeder system into our specialist areas, and that certainly needs to be considered. We know, from when we did the task force, that there was a 30 per cent attrition from beginning to end. That is no different, apparently, from a lot of other groups. Taking that on board and still with people coming in and out of the work force, we believe that that is right.

Ms Wallace—Those projected numbers are based on our futuristic projections about population ageing, nurse ageing et cetera.

CHAIR—How futuristic: five years?

Ms Wallace—The crunch for us starts to come in about five years but it becomes quite significant 10 to 20 years out.

CHAIR—Well, if Queensland will advertise it is the place to come and die you might have to live with your difficulties. That is what they used to tell me. We poor people in Adelaide were told we were hopeless. Everyone was going to Queensland to die so I hope that is not strictly the situation. Are you actually advertising for nurses from overseas?

Ms Norrie—My understanding is some of our organisations, especially specialty areas like oncology where we have had difficulty even in the specialist oncology units—

CHAIR—Where are you advertising and who are you getting?

Ms Norrie—We, as part of our Think Nursing web site, use www.seek.com.au. We get people from the UK, Ireland et cetera who seem to come to Queensland.

CHAIR—It seems to me, from what we understand, that nurses are moving around the world. There is a wave of them. They are trained in England and then go to Canada. One of the things we do know is that Australian trained nurses are very well received everywhere which is, at least, a very big plus. Are you going to continue advertising overseas?

Ms Wallace—We do not have a state policy on advertising overseas. We have 38 districts and they manage their own recruitment at the moment and some of those districts would advertise overseas for specialty nurses but there has been no large overseas campaign that has come out of Queensland. We seem to pick up quite a lot of nurses from other states' campaigns who then come to see the sunshine state.

CHAIR—A good reply, Ms Wallace. They might be coming here to die but they are also coming here to live; isn't that strange?

Ms Wallace—That is right. The number of Irish accents in our rural remote facilities is quite amazing.

CHAIR—Where are the Irish accents coming from—Victoria?

Senator WEST—Ireland.

CHAIR—Thank you, team. That is wonderful. I have two very quick questions. Can you provide the committee with any information about the costs of agency nurses?

Ms Norrie—Yes.

Ms Wallace—Yes.

CHAIR—Will you take that on notice but if you can tell us on the record how much more they charge or cost—

Ms Wallace—We actually brought the agency schedules with us.

CHAIR—Are they 20 per cent above?

Ms Wallace—Up to 40 per cent.

Ms Norrie—Up to 48 per cent.

CHAIR—48 per cent above?

Ms Wallace—Up to, depending on the agency. There are a number of agencies and they charge a variety of on-costs but we did bring the schedule with us.

CHAIR—That would be very helpful. Is your government thinking of doing what Victoria has done, which is to prohibit the use of agency nurses in the public sector, saving them, they say, $20 million per annum?

Ms Wallace—At this point, no. We are using agency nurses. In the snapshot week, something like eight per cent of nurses were from agencies or from our casual pools. A lot of hospitals run casual pools that do not necessarily require them to go through agencies. We do not differentiate that in our data.

CHAIR—Do you think you should?

Ms Wallace—I do think we should and I think we need to start looking much more closely at that issue. I know that some of the directors of nursing are looking at it within their own facilities and I think Sue has been meeting with them about what sort of strategies we can put in place to better manage that. It is not a matter of prohibiting agency at this time. We are more keen to look at exploring other ways and using agency as our backstop.

CHAIR—My last question is: do you have a chief nurse or are you two it?

Ms Norrie—I am the principal nursing adviser.

CHAIR—So if anyone wants to ask the Queensland government anything about nursing, they ring you?

Ms Norrie—That is correct.

CHAIR—Thank you for your evidence and valuable time in attending the hearing today.

Proceedings suspended from 11.12 a.m. to 11.27 a.m.

NASH, Ms Robyn Elizabeth, Director of Undergraduate Programs, School of Nursing, Queensland University of Technology

YATES, Professor Patsy, Director of Postgraduate Studies, Queensland University of Technology

CREEDY, Professor Debra Kay, Professor of Nursing and Health, Faculty of Nursing and Health, Griffith University

REILLY, Mrs Roslyn Corinne, Head, Department of Nursing, University of Southern Queensland

CHAIR—Welcome. 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 the committee would give consideration to your request. I need to remind you that the committee is protected by parliamentary privilege and anything you say is likewise protected. If you should give false or misleading evidence, that could constitute a contempt of the Senate.

The committee has before it your submissions 736, 749 and 804. Do you wish to make any alterations to those submissions? If not, I will ask you if you would each like to make a brief opening statement and then field questions.

Ms Nash—The School of Nursing at QUT has been in existence since 1981, which is the longest period of time in Queensland for tertiary nursing programs to exist. We have an undergraduate program, as you are well aware, and we also have postgraduate programs. In the undergraduate area, our main nursing program is the Bachelor of Nursing program but we have two variants of that which I would like to just briefly draw your attention to. We have an articulated enrolled nurse program specifically to progress enrolled nurses to the RN status if they wish to do so. We also have a graduate entry program which is designed specifically for people who have an undergraduate degree other than nursing who now wish to come into a nursing program to further their career within a nursing context. In addition to those, we have two double degrees to provide additional interest for people who choose to do nursing but wish to combine it with another discipline area. At the postgraduate level we have graduate certificates, graduate diplomas and masters programs in about 10 specialty areas now. We have about 200 students who are doing those course-work programs and we have about 60 students doing research programs.

From the undergraduate perspective, we have a very strong enrolment, attrition and employee statistics record at QUT. This year, 430 students commenced the three-year program at the school of nursing at QUT. We have an attrition rate of about 12 per cent overall in the program. That figure has not changed very much in the last five-year period. The employment rate for our graduates is around 97 per cent, so it almost all graduates are employed. That includes full-time and part-time employment, but almost all our graduates seek employment. Most of that, to my knowledge, is within the nursing sector. So most people go into a nursing job after completion of the course.

Our program is comprehensive, in that we do try to provide preparation for students to enter any one of a variety of areas in nursing after they finish the program. Those include the aged care area, as well as the more traditional areas of nursing work. The clinical placement program we have also provides opportunities for students to obtain practice in areas such as aged care—not so much in the first year of the program, to pick up on an issue that Sue Norrie was alluding to: we offer that more as a speciality practice area for students in the final year of their program. We also offer a very strong rural placement option for students in the final year of the program, so that they can obtain the opportunity to undertake placements in that type of area, with a view to their possibly going back into that type of area after they finish the program. I might leave the overview of that and pass on to the next person.

Prof. Creedy—Thank you for the opportunity to present to the committee today. I believe the inquiry was precipitated by a crisis in nurse education both within the health care sector and the university sector. The Griffith University submission clearly outlines three major issues on page 7 that indicate the stronger need for an intersection between health and the tertiary sector to support the developing practice of students during their educational programs at all levels, to support beginning practitioners as they assume their professional role and then to provide on-going support for the specialisation and advanced practice and training of clinicians, so that they may be proactive and responsive to the changes within the health care sector. This is where the issues lie at their fundamental best.

Ms Reilly—We are a regional university, and much of what I say will be similar to what QUT has said. Nevertheless, we are about a two-hour drive west of Brisbane, and so our focus is more regional and remote, rather than looking at the metropolitan area. We started at Toowoomba in 1990, and we offer a Bachelor of Nursing (Preregistration) and a Bachelor of Nursing (Post-registration), to allow registered nurses to convert their hospital certificates to bachelor degrees.

We decided to have three niche areas for our postgraduate areas. They are mental health, midwifery and rural and remote. With the midwifery and the mental health, we use a clinical component where the students are actually employed at the facility and they undertake the theoretical component through the University of Southern Queensland. We work in partnership with some of the hospitals. Believe it or not, Cairns, which is in Far North Queensland, is one of our midwifery partners, as well as the Toowoomba hospital at the moment. We are hoping to get more areas, but at the moment midwifery seems to be an area to which for some reason a lot of registered nurses do not seem to be attracted. Our graduate diploma of nursing mental health is very attractive to a lot of students, and that is probably because they do get scholarships from Queensland Health.

We commenced our advanced nursing practice only at the beginning of this year. It has a very heavy clinical component in it. We do give exemptions to students who have undertaken the isolated practice and immunisation programs offered by Queensland Health. We also have a graduate diploma Master of Nursing and students can more or less elect to go on whichever pathway—education, management or research—for that. We also offer PhDs. At the moment we have approximately 600 preregistration students, having no difficulty whatsoever this year—or any year for that matter—to get enough applicants. We have really got too many this year; nevertheless, we will have a reasonably high attrition rate—probably about 15 per cent. It seems to be a bit higher for some reason than QUT.

Our last employment rate survey was at 99 per cent. We do have two campuses. We have one at Wide Bay, which only commenced this year and it took 42 students. In Toowoomba we have approximately 600. Our clinical placements are very diverse and we do include the aged care sector and any sector in fact where nursing actually takes place. We use industry, community, wherever.

We use a combination of a facilitative model and a preceptor model for our clinical supervision. We use facilitation in the first and second years, and in the third year we use a preceptor model. The students really like the preceptor model because they feel that they are included in the clinical area and it is not a case of them and us; they feel part of the whole establishment. We are finding that the preceptor model works extremely well.

CHAIR—Let me ask each of you a couple of quick questions. All of you seem to have nodded to say that you have been oversubscribed with people applying to start as RNs. Are you all oversubscribed?

Prof. Creedy—Yes.

Ms Nash—We have 430 new students this year.

CHAIR—Did you have 500 applicants?

Ms Nash—We had about 600 first preferences.

Prof. Creedy—We regularly have three applications for every place.

Ms Reilly—We probably have two.

CHAIR—Would all of you have some attrition, maybe 12 per cent or 15 per cent?

Prof. Creedy—It is around 18 per cent.

CHAIR—When is that attrition rate? Is it in the first couple of weeks or months before the college finally sets out what everyone is getting? Do you know how many people drop out in the first month or two as they actually settle for doing science or something else?

Prof. Creedy—I believe around 20 per cent would drop out within the first month of commencing the program.

CHAIR—Are they actually dropping out or exercising their option, because they put their names down for four courses—and nursing was one of them—and they have chosen one other?

Prof. Creedy—No, they are dropping out.

Ms Reilly—It is a combination of both, actually—dropping out and exercising their option to take up another offer.

CHAIR—QUT?

Ms Nash—I think our experience may be a bit different. When we talk with first year commencing students at the moment, because the major date for first year commencing students is, of course, the end of March in terms of withdrawing without penalty, a lot of people have been thinking about whether they wish to continue or not.

I think it is reasonably clear that there is a variety of reasons why people wish to withdraw either for a period from the course or withdraw from the course altogether at this stage. I do not have any figures per se but my feeling from previous years is that, at this point in time, it is relatively small in terms of the numbers of people withdrawing. But their reasons are personal to some extent, in the sense that they have come in with certain expectations about what they think they can manage vis-à-vis their personal circumstances, which are family, work and whatever else. They have come in, they have a feel for what they are actually in for, so to speak, and they have weighed up whether or not that is all going to fit together for them. So there is a variety of those sorts of reasons at this stage.

CHAIR—Is that what you were talking about, too, Professor Creedy?

Prof. Creedy—Yes, it is. Predominantly nursing has attracted a high proportion of mature age women who usually have previous work history and family commitments. They embark upon university life and really are unprepared for the changes that are required in their personal and private life. Predominantly, I find that many women experience marital breakdown or distress as a result of converting perhaps from a part-time work role to a full-time study and part-time work role. Many of our students will work part-time in order to support themselves. So if you combine that further with child-care rearing and home duties, it is a real pressure on women.

Ms Nash—To add to that, our experience is probably the same as for the other universities. We find that approximately half of our commencing student cohorts are other than school leavers—in other words, what we generally refer to as mature age entry. For us, that varies between, say, age 20 up to probably around age 45, with the majority being somewhere between 20 and 35.

CHAIR—How many of those mature age students have done nursing of a different sort?

Ms Nash—I do not know the actual figures, but I would say quite a few—either as enrolled nurses or AINs.

Prof. Creedy—I would hazard a guess that it would be 50 per cent of them.

Ms Reilly—That would probably be the same for us as well.

CHAIR—How many of your students—the 99 per cent—get work overseas, or don't you know?

Prof. Creedy—On average, Griffith University would have around 300 graduates a year, and I recall processing around 20 applications per year for UK registration purposes.

CHAIR—Okay, 20 out of 300. What about QUT?

Ms Nash—I would say it is probably similar. Again, most of our processing would be for the UK—I think about the same proportion. There is increasing interest in the United States but with attendant difficulties in gaining registration in that country.

Ms Reilly—We seem to have higher figures than that. It seems that almost every week we get an application for the UK or Ireland. The States is becoming very popular but it is very difficult for the States.

CHAIR—What percentage of your course gives RN students hands-on clinical experience in first year, second year and third year, and has it changed of recent times? You have one second each.

Ms Nash—About 50 per cent of our contact hours is in off-campus clinical placement.

CHAIR—Over three years?

Ms Nash—That is right; over the three years. The proportion, though, changes each year of the course. In the first year, we have a relatively small proportion. It increases in second year and then increases again in third year, particularly in the final semester as the students prepare for transition to the work force. So in the last semester of the third year, eight weeks out of 13 are now used for direct clinical placement.

Prof. Creedy—Fifty per cent of our program is dedicated to clinical experiences that range from working on campus in a simulated clinical laboratory to clinical practice in a range of settings. Just recently, Griffith implemented a new curriculum and we reduced the number of clinical hours in our curriculum from 1,200 hours to 900 hours in hospital or community based settings, because we simply cannot afford to have students doing long clinical hours.

Ms Reilly—Our off-campus experience would be approximately 45 per cent, with a large laboratory on campus providing simulated experience.

CHAIR—Professor Creedy, what can't you afford—the supervision, the teachers who have to go with the students or what?

Prof. Creedy—Supervision. The requirement of the Queensland Nursing Council is that students are usually supervised on a one to eight ratio. Clinical facilitators are paid around $34 an hour. They are usually expected to be a level 2 clinical practitioner, a well-experienced practitioner. Increasingly, clinical agencies are now requesting that we also make a payment to them, because they believe that students take a great deal of staff time away from direct patient care into teaching and supervision type activities. So, increasingly, we are being asked by agencies to pay a placement fee.

Senator KNOWLES—This is the $7,000 that you referred to to supervise two students during a six-week placement?

Prof. Creedy—That is correct.

Senator KNOWLES—That is an interesting equation: $7,000 for two students for six weeks. Is that common practice?

Prof. Creedy—No, but it is beginning to become common practice. That was an exceptional circumstance that started the thin edge of the wedge, and now we are being hit with increasingly systematised costs associated with clinical practice.

Senator KNOWLES—What would the range be?

Prof. Creedy—It is varying.

Senator KNOWLES—If $7,000 is the upper limit, what would the mean average be, roughly?

Prof. Creedy—It is negotiated on a case-by-case basis by agencies. Currently, I believe there is encouragement from a Queensland Health perspective to establish what is known to be a standardised rate. That rate has not been publicised as yet, but my colleagues may be aware of that.

Ms Reilly—With the clinical facilitator model, either they release a registered nurse from the facility and we pay them the $34 an hour or, if they are going to be working there but not releasing one of their registered nurses, we pay $35 an hour per student per day. So if there are eight students, we are more or less paying for a day. With the preceptor model, we have not been paying, except for a lump sum to the facility. Sue Norrie, one of the last witnesses, indicated that Queensland Health are working on a plan for us to pay for clinical. Paying for clinical experience is going to put a lot of universities into dire straits—in the preceptor model.

Senator KNOWLES—Did you say $34 per hour per day?

Ms Reilly—Approximately.

Senator KNOWLES—For how many weeks?

Ms Reilly—It depends on how many weeks the clinical is.

Senator KNOWLES—What would we normally be talking about at that rate?

Ms Reilly—In first year, probably three weeks in a semester. It is probably different in the other universities, but at USQ we have the facilitator model for first year and the preceptor model for second and third years.

Ms Nash—I can make a comment from QUT's perspective. Across the whole of the program, we have 20 weeks of off-campus placement—in other words, clinical placement—in hospital and other settings. In addition, and like the other universities, we have an on-campus program that also needs to be facilitated. The rate that we are paying our facilitators is actually

higher than the rate that Griffith University and USQ are paying, and that is interesting. The award that we are required to use, at least at QUT, means that we are paying in the vicinity of $40 an hour, which includes on-costs at the moment for our clinical facilitation staff. So, with our clinical program of 20 weeks per student across the three years plus our on-campus facilitation, our projected clinical cost for this year is around $1.3 million. It is a substantial cost.

Senator KNOWLES—Can I come back to the questions that the chair was asking a little earlier about oversubscription. Professor Creedy, I notice that under the heading 'The Issues', on page 4 of your submission, you mention the Morgan Image of Professions Poll's findings on what people think of nurses, yet on pages 8 and 9 of your submission you say:

The public face of nursing should be promoted to the general public as a caring, noble, important profession ...

I would have thought you had the runs on the board already, as recognised by the Morgan poll. Also, the QUT submission talks about the national marketing campaign to promote nursing as a career option for school leavers. When I put all that together, I am getting a bit of a mixed message: on one hand, people think that you are a bunch of saints; on the other hand, those involved tend to feel that they are anything but saintly; you are setting out to try to elevate the opinion of the public to nursing and also the opinion of students to nursing, yet you are oversubscribed. How do we throw all those balls into the air and come down with something that we can manage and get out teeth into in a way in which we can get more students into nursing and elevate the opinion of nursing as a profession amongst the community and amongst those who might wish to go into it?

Prof. Creedy—I believe that the public has an idealised image of nursing, as you identified: the kind, caring, nurturing type of individual who will be by the bedside. When I talk to members of the public they believe that nurses do not need to be educated, they simply need to be kind.

Senator KNOWLES—Until that person gets sick.

Prof. Creedy—Yes. Even within the health care system nurses constantly defer to the role of the doctor and I believe that nursing, particularly in the advanced practitioner role, could take more of a lead in providing care directly that does not require costly medical services and intervention. This is particularly the case with midwifery where obstetricians have cut out a niche in terms of normal vaginal delivery. In fact, obstetricians should be devoting their services to the complex delivery and the pathology of childbirth—not the normal delivery, that should be catered for by nurses and midwives in that setting. So until we can have nurses in the health care system taking a leading role and making patient care decisions, it is less likely that members of the community will value and highlight the role of the nurse as the primary carer and provider of services.

Senator KNOWLES—Are you saying that while the public think you are terrific they think you are terrific for the wrong reasons?

Prof. Creedy—That is correct. That does not help us industrially. If the public complained about service care delivery, nursing would not have the crisis that it is in at the moment. If the

public complained about long waiting lists, I believe there would be a greater emphasis placed on service delivery. At the moment the dollar rules the bottom line.

Senator KNOWLES—Can we go on to a subject that is attached to all of that: the oversubscription into universities which is occurring yet we are also talking about national marketing campaigns—Ms Nash has talked about that as well. Also, there is the interesting question that has not had a lot of focus—the attraction of more men into nursing. Men make wonderful nurses, don't they?

Prof. Creedy—Yes.

Senator KNOWLES—Who wants to comment on the contradiction between running a campaign for something that is already oversubscribed?

Ms Reilly—There are two facets to this and one is that we are oversubscribed because students do want to do nursing, they genuinely want to become nurses. The problems occur when they become graduates and move into the work force and then get a reality shock. The other is that, quite often, they feel that they are not being supported in the clinical area. There is a lot of talk about the graduates being work ready and there is a need to look at the workplace being graduate ready. So we have this dichotomy: people really want to be nurses but, in fact, it is not what they expect it to be when they actually go out into the work force. The problem is that the minute they arrive they are expected to be a fully functioning registered nurse, an experienced registered nurse and they are not able to do that. A lot of them leave because they feel they cannot manage, they do not know anything, they are ineffective and they can find something else to do.

Senator KNOWLES—I want to hear the opinions of the others on the same subject, but just on that question about them not being equipped to hit the ground running, do you believe that is due to the lack of clinical practice, the lack of exposure of those undergraduates before they qualify?

Ms Reilly—There could be an element of that but I challenge any professional to be able to hit the ground running. In this case, I do not think nurses are any different. For example, we would not expect that from a resident doctor when they come out. It is the registered nurses who usually educate them in lots of areas—

Senator WEST—That is right.

Ms Reilly—and it has even been said, 'How would we manage, who would do the training if the registered nurses didn't do it?' There is a mismatch of expectations: they expect the registered nurse to really get to it on day one, yet they would not expect that of any other professional. If you speak to any student they would say that they feel they do not have enough clinical experience. We would feel that as well but short of giving them clinical experience every day of the week they would still think they did not have enough clinical experience. So there is an element of that but I think it is more a mismatch of expectations.

Senator KNOWLES—Are there other comments on the marketing versus oversubscription issue?

Ms Nash—A comment I would like to add is that, although we have very strong numbers at QUT, I still think the issue of a national campaign is an important one because in talking with our commencing students again just quite recently, they made me aware, again, of some of the reasons why they have come in the face of comment they have had from both nurses who are already in the system and friends and family and so on. In the main, those sorts of comments have included questions like, 'Why would you do nursing? It's just a menial job. It hasn't changed much in the last 20-odd years—there are lots of other things you could be doing. Why are you doing nursing?' In the face of that they have come in to start the course with a sense of hope that it will not turn out to be quite as bad as what some people have already painted it to be.

In terms of the campaign, one of the benefits will be that we will start to be able to attract people who are put off by that type of comment and who do not have the courage, so to speak, to get on top of it and say, 'I'll give it a go, anyway.' So we will attract a wider range of applicants into the courses. My other anticipation is that we will attract people with increasingly, perhaps, better academic profiles to come into the courses. One of the issues in just simply increasing numbers is that we could be looking at a situation where we are going further down the academic preparation scale to be able to do that.

Senator KNOWLES—We have had quite a lot of evidence of that.

Ms Nash—We were able to increase it this year at QUT, which was wonderful, with the large numbers.

CHAIR—From what to what?

Ms Nash—This year our OP went from 13 to 11, for our full-time students—so a higher OP with a slightly higher number of commencing students.

CHAIR—I do not understand OP—from 13 to 11?

Ms Nash—It is a Queensland tertiary entrance score, and I am not quite sure how it equates with the TER.

CHAIR—We might stop on that one and ask Professor Creedy to address Senator Knowles's question.

Prof. Creedy—I have two comments in relation to that. There is a high demand for nursing places in universities, and currently there is limited opportunity for individual universities to be responsive to work force needs. Our figures in terms of numbers accepted are set by DETYA so we have an academic registrar who looks at nursing and says, 'There is a three for one demand for these courses; I'll over enrol you so the overall university enrolment picture is filled in order to fulfil DETYA requirements.' However, for health care related programs that creates a lot of difficulties because we are not responsive to work force needs at the moment. We have limited flexibility in the system to increase and decrease our enrolments according to need and projected numbers.

We also have a system that is not necessarily sympathetic to the demands of practice based disciplines within the university sector. They think we are like an arts course where we can cater for 100 students in our lecture theatre or 1,000 students, when in fact that is not the case. For every overenrolment—and currently Griffith is 12 per cent overenrolled in nursing—that is a science laboratory space, a clinical and nursing space, a clinical placement that needs to be found, and a clinical facilitator that needs to be found. That is problematic.

In terms of the advertising campaign, I agree with my colleague Robyn Nash in that we are targeting to educate the community about what nurses can do because it is only through public advocacy that they can say, 'I would like a nurse to take care of me.' We are more likely to touch base with a number of minority groups that currently are not attracted to nursing, including students from non-English-speaking backgrounds and men, who can make a very valuable contribution to the health care professions, and we are less likely to get those high-flying first year students out of high school who really could set the discipline on fire in terms of innovation and critical thinking.

Senator WEST—I would like to follow on with the attrition rate question. You have given us the attrition rate for nursing in your various institutions; what is the attrition rate of the other courses in your institutions? There is no point in measuring nursing on its own; you have to measure it in comparison to what other courses are doing at your university. Do you know what the general attrition rate is within the university?

Ms Nash—I could make a general comment from QUT's perspective. We look at attrition in two ways with respect to our nursing course and with respect to other courses in the institution. We look at, first, attrition from the first year, which is calculated at the end of the first year, and then overall attrition. Our first-year attrition at QUT is about 18 per cent, which is quite comparable, in my knowledge of other courses, with other courses. Our overall attrition, as I mentioned before, is about 12 per cent, which again is very comparable with other courses in the faculty of health and other courses across the university. I cannot give you specific instances, but in general terms both of those attrition indices are comparable with other courses. So we are not actually sitting outside of other experience.

Senator WEST—What percentage actually passes at the end of the three years?

Ms Nash—I probably cannot give you that in terms of proportion. We certainly know the number of students we graduate each year, and it is roughly similar to the number that my colleague from Griffith was talking about before. We have been graduating about 280 to 320 or 340 students. Obviously it varies a little bit each year. But I could not give you that figure in terms of proportion.

CHAIR—That is over 400 who come in?

Ms Nash—The number has varied over the last few years, when we have had intakes of 420 and 370; 320 a few years ago. It may be possible to calculate that out. I do not have that figure but we could probably look to see whether that could be provided, if that was considered to be important.

CHAIR—At this stage can both of our remaining speakers answer both Senator West and Senator Lees, and then it is back to Senator West.

Prof. Creedy—I believe that Griffith's average attrition varies between 15 and 25 per cent, with nursing around 18 to 20 per cent in terms of attrition.

Ms Reilly—I am not sure with nursing as far as the other disciplines are concerned, but within the faculty of sciences, where nursing is based—we are the only health discipline at USQ—I would suggest we have a higher attrition rate. The reason for that is that we have got a very structured curriculum and we have a process in place where students have to meet a prerequisite before they proceed to other units. This has the effect of increasing the course by 12 months, and I suggest we could have a higher attrition rate because of that. A lot of students do keep on going, but our attrition rate is probably higher between first and second years. One reason would be our prerequisites that we have in place. The other is that we do get quite a few students from Brisbane and they tend to try to move back to Brisbane because their home is based there; it is easier for them to live at home in terms of the cost of accommodation. So I would suggest, but I would have to check, that we would probably be higher compared with other courses.

Senator WEST—What recognition is given to those who have actually got enrolled nursing qualifications? Do they get credits given or is it a shortened degree course? What is the situation with them?

Ms Nash—At QUT, depending on the course that the person has done originally to obtain their enrolled nurse qualification, we offer one of two different sets of opportunities. If they have done the TAFE course which leads to the diploma, we offer them credit for the whole of the first year of the RN course, so they come in and do a shortened two-year program, two years out of three. If they have done their enrolled nurse qualification prior to the inception of that course, in other words they have done one of the older hospital based certificates, we offer them some credits within the first year of the program but it is obviously less than that first year.

Prof. Creedy—We have a similar arrangement. Students who do not undertake a recognised program at diploma level, for example, are assessed on a case by case basis. Normally they are less likely to receive credit for the science based subjects and more likely to receive credit in the nursing based subjects because often they have good basic nursing skills.

Ms Reilly—We are similar; if they have done the diploma course we give the year the same as the other universities. We probably do not give as much for students who have done the enrolled nursing course through a hospital based system. Each one is assessed on merit.

Senator WEST—Are you running any distance education programs?

Ms Reilly—Yes.

Senator WEST—How are they working? How popular have they been? What is the set-up for them?

Ms Reilly—For preregistration?

Senator WEST—Yes.

Ms Reilly—No, sorry, we have postregistration.

Senator WEST—Do you not have distance education even for your enrolled nurses?

Ms Reilly—No.

Prof. Creedy—At Griffith by the end of this year all of our undergraduate subjects will be web based, which allows some flexibility for distance education. The opportunity came up for Griffith to expand and open up a new campus at Logan, which provided the opportunity and impetus to really invest in flexible delivery. Students are required to come on campus to undertake their clinical practice components in the simulated nursing laboratory. So it is not truly distance education in that regard at an undergraduate level. At a postgraduate level we are increasingly putting our masters programs on the web. Students in those programs who are already registered nurses are able to make practice arrangements at a facility that is close to their locality. They are not required to come to the university for classes or practice.

Ms Nash—At QUT we offer final semester students the opportunity to undertake some of their studies in the distance mode. That is relatively new to us; we commenced it last year. We have evaluated it and it was a very successful initiative, particularly for students who live on the Sunshine Coast and who have to commute to the campus on a fairly regular basis. They thoroughly appreciated the opportunity to undertake some distance study so we are going to continue that opportunity for students in their final year. In addition, we use various other means of flexible delivery, as my other colleagues do, using web based technologies. In the postgraduate area, where Patsy could comment, there is a very different sort of scenario.

Prof. Yates—In the postgraduate area we offer 10 different specialties. It has been interesting that all of those specialties are now offered by distance mode, except for midwifery and mental health. Over the last few years, there has been a huge increase in students choosing to study flexibly. This year, even though we are right in central Brisbane, 80 per cent of our students in those specialties are choosing to study in distance mode because of the flexibility it offers. When we are talking about flexibility, we are not just talking about distance; we are talking about weekend study schools that they might come to or a whole range of interactive modes on the web et cetera. For registered nurses, it is certainly becoming a very important way to offer education. It is very popular.

Ms Reilly—Could I add that all of our postgraduate courses are external. We have no internal postgraduate courses.

Senator WEST—How are all of you offering your midwifery courses? Are the students in the facility, in the midwifery hospital, as well as doing study through you in a block formation? How is it working in that respect?

Prof. Yates—Our midwifery program is not necessarily linked with one particular clinical agency, although we are looking at some of those sorts of models for the future. Students need to do—as well as coming and doing the theoretical component, they are often still working full-time—many hours of clinical practice. We have to negotiate that with their health care agencies.

We are finding that it is not a terribly effective way and we are looking at how we can set up some partnerships with health agencies in midwifery education.

Prof. Creedy—Griffith's program is currently offered through our Logan campus. Core subjects within that program are offered in flexible mode, but the clinical based subjects are offered on campus. At Logan, we are also investigating innovative models of practice. For example, one model is a midwives' clinic where students can work with midwives in providing antenatal and postnatal care for pregnant women. We are hoping that those sorts of models will enable students to develop good clinical skills that will equip them better for independent practice at a later date. Like my colleagues at QUT, we use a range of other facilities depending of the location where the student lives. But, by far, the students who do better in those courses are those who receive some payment for their clinical placement because, once again, we are dealing with mature age women with family commitments who have a life that they have to support.

Senator WEST—They do have a range of clinical nursing skills, maybe not midwifery—

Prof. Creedy—That is right.

Ms Reilly—For midwifery we have a partnership model. At the moment we are with two hospitals and are negotiating with others. The students are employed for five shifts a fortnight but can work more if they want to or if the facility wants them to. We developed four CD-ROMs for our flexible delivery which the students purchase and work through. It is situated learning and it seems to be working very well. We do have clinicians in the partner hospitals that supervise their clinical practice so they are being paid at the same time as they are actually undertaking the theoretical component. It is a two-year program. They do a year in preclinical and then a year in the clinical facility.

Senator WEST—How many deliveries do they have to do?

Prof. Creedy—30.

Ms Reilly—20.

Prof. Creedy—I thought under the Nurses Act it was 30.

Prof. Yates—I am not sure.

Prof. Creedy—I will be open to correction on that. I thought it was 30.

Senator WEST—I had to do 20.

CHAIR—I had to do 20 but I wasn't being a nurse.

Senator WEST—Observe a hundred. You did not mind. That was enough for you.

Senator LEES—I would just like to quickly look at priorities. If we were to paint a picture that was becoming so desperate that either state or federal governments did agree to put in some more money, where should we spend it? Should we be looking at recruitment and getting more students in? Should we be looking at putting the money to clinical places or is it after they have qualified that we should be putting more support in? What do you think are the priority areas?

Ms Reilly—I really think there are two priority areas. That is to assist with the clinical in the preregistration course but also to supply some funding to the clinical placements areas when they graduate to allow them to have at least three to six months, at the minimum, where they could not be seen as being fully- fledged professionals, if you like, or registered nurses, to allow them the chance to be integrated into the area and become able to manage on their own as a registered nurse.

Prof. Creedy—I believe we have gone full circle again. I refer you to page 7 of our submission and to those three priority areas: support for undergraduate placements, support for transition to the workplace and then support for specialisation.

Senator LEES—That is postgraduate training?

Prof. Creedy—That is correct. We are not attracting the numbers to postgraduate courses because usually they are HECS liable and students lose income to come and study in our programs particularly those practice based courses, such as midwifery and mental health, that require a lot of clinical placements for endorsement.

Ms Nash—I would entirely endorse the comments which have been made by my colleagues. I think there is probably little value in trying to attract more and more people to come in and do the programs if we cannot support the clinical program. Clearly that is an issue from all of our submissions which does need to have some sort of resolution into the future. We are also not going to be winning overall, I don't believe, unless we can support their transition into the work force with some well-structured programs that are effectively managed and are monitored on the outcomes that they are able to achieve. My view would be that that needs to span the first 12 months of the employment period. I base that on the outcomes of projects that I have been involved with, most recently with the AUTC. An AUTC project clearly demonstrates that in the first six months graduates are essentially finding their feet, and in the second six months they are consolidating their experience as a new registered nurse and they begin to fly. After that they are well prepared to—

Senator LEES—Would you have some documentary evidence?

Ms Nash—I can supply that.

Senator LEES—That would be most helpful. Can I very quickly look at income? An issue that has been brought up is whether people can afford to stay in nursing because these days students generally have to work part time somewhere else. I take it that a lot of those who come in as enrolled nurses continue to work so they are not quite as much of a worry as getting the school leavers out into some sort of nursing based employment area. In Queensland, how long do you think it needs to be before they could have some qualification where this new intake, say

after a year, year and a half or two years, could be recognised as an enrolled nurse and therefore employed in a nursing home or in some facility as an enrolled nurse? Has that been looked at?

Ms Reilly—I think you should put that question to the Queensland Nursing Council.

Senator LEES—Looking at the course that you offer, when would you be confident that your students had the experience and qualifications necessary to take on an enrolled nursing job?

Ms Reilly—I would say at the end of the first year, but certainly at the end of the third semester, which would be 18 months into the course. They would be at the same level as an enrolled nurse and could probably carry out more than an enrolled nurse could.

Prof. Creedy—Griffith University has a campus at the Gold Coast and so we have a priority partnership with Gold Coast Hospital. We had embarked on discussions to enable first-year students to be employed as AINs—assistants in nursing—but that was not supported by the Queensland Nurses Union, so that arrangement did not go ahead. That was one agency that was prepared to work with students after their first semester, when they had managed most basic care issues like bathing and activities of daily living.

Senator LEES—We heard today that there are people out there working who are basically off the street.

Prof. Creedy—That is right.

Senator LEES—So the union would not accept someone who is in university, but the union does not have a say about people coming in off the street?

Prof. Creedy—That is exactly right.

Ms Nash—There are a couple of issues. A lot of our students work during their course. From anecdotal evidence, a lot of those students find employment as AINs during their course. The ENs are in a different position; most of them continue part-time work as an EN. For those who are not ENs, the majority seem to be working as AINs.

Senator LEES—What would the pay rate be for an AIN?

Ms Nash—I have absolutely no idea, not a clue. But to address the second part of the question, which is at what point might they be able to qualify in effect as an EN, from our perspective it would require the restructuring of our course. The course that we have is designed for preparation to become an RN over three years, so the clinical component in the first year is relatively small. Over the three years, it ramps up towards the end of the course. To say that they could exit in effect after a year would give them some theoretical preparation—which would be quite reasonable in an EN role—but they would not have nearly as much clinical work as an EN would when they have finished their EN program.

Senator LEES—I was not necessarily looking at exiting, although I guess that would be an option, but at being able to work in the health area.

Ms Nash—They work in the health industry as AINs. To work as an EN, they would need to be endorsed through the Queensland Nursing Council. To achieve that, there would need to be a program that had been approved by the Queensland Nursing Council to enable them to be endorsed. That is why I make my comment about the course and about possible restructuring that would need to be considered.

Prof. Creedy—I want to make a point of clarification to Senator Lees. The QNU did not support that arrangement, because their position was that student nurses would occupy registered nurses' placements. Their position was that they wanted to maintain those vacancies in order to encourage the hospital to employ registered nurses. But the hospital could not employ registered nurses and that is why they were looking for alternative models of employment and recruitment. I just wanted to clarify that.

Senator LEES—Thank you.

Senator McLUCAS—In regard to indigenous participation in nursing, can you give me an idea of how many indigenous students you have at your campuses? We heard earlier that there are four scholarships offered by Queensland Health for indigenous nurses. Can you give me a picture of what you are doing on that issue at your campuses?

Ms Reilly—We are consciously making a move towards including indigenous students. We have recently employed an indigenous nurse academic who is very passionate about indigenous students. Our numbers are increasing. Queensland Health gives scholarships and the Royal College of Nursing Australia does as well. We have had students who have received that scholarship—I think it is approximately $30,000. I cannot think of the full name of it now. Most of our students received that scholarship. We have also included indigenous health in our curriculum.

Senator McLUCAS—That was my next question.

CHAIR—In what numbers?

Ms Reilly—We would probably only have about eight in the preregistration course.

Senator McLUCAS—Is that increasing or is it stagnant?

Ms Reilly—It is increasing.

Prof. Creedy—This year, Griffith accepted eight indigenous students into its programs. Griffith has a unit called the Gumurri Centre which is for indigenous tertiary studies. They have had a very proactive outreach program into the high schools, and they believe that, through their proactivity and having a presence in local communities and high schools, Griffith has been able to effectively double indigenous enrolment rates, although they are still low.

Ms Nash—We also have a unit at QUT. It is called the Oodgeroo Unit and it has similar sorts of functions to those just described. We have a person in the school of nursing who works with the Oodgeroo Unit to promote the nursing course more specifically to students from the school of nursing's perspective. I am not quite sure of the figures, but I think we have about 36 indigenous students across the program at the moment, and this year I think we enrolled seven new, commencing students.

Senator McLUCAS—I should also have asked about attrition rates in the same question. Are they higher than for non-indigenous students?

Ms Reilly—They are getting better.

Prof. Creedy—The Gumurri Centre, through our liaison with it, has requested more flexibility with students, and over the last two years we have implemented a mentoring program where those students have one-to-one contact, usually with a staff member or a third year student. Those individuals are paid a small honorarium of $20 a week or so. They spend time with the student, talking about any university related issues; they will also provide academic support to the student, going through their assignments or dealing with any questions they might have in relation to their courses. I have a colleague with one of the people doing that program, and she finds it really satisfying to do that work.

Ms Nash—I do not have a good sense of what our projections are for that particular group, but retaining those students requires fairly resource intensive activity, which is what was being described. The thing I would add is that we do try to place our indigenous students within indigenous communities for clinical placement if that is a choice they wish to take up. Whether that is an option they wish to pursue varies from person to person, but we do use placements at Thursday Island and other places. If that is a culturally appropriate choice that a person wishes to take up, the benefit is that they might wish to become employed back in those communities.

Senator LEES—Do you do that for non-indigenous students as well?

Ms Nash—We do not preclude non-indigenous students from taking those sorts of opportunities but, interestingly enough, they have not really sought them out either.

Ms Reilly—We also have a centre for indigenous students at USQ. It is called Kumbari Ngurpai Lag, and they supply that support as well. They arrange tutoring for the students, and we do put a lot of resources into helping indigenous students.

Senator McLUCAS—I am aware that in education in Queensland, as well as in child care, there are remote delivery models—RATEP is the model for teacher education and RAATSICC is, I think, the model for child care. Do we have anything like that in nurse education: that is, remote delivery on site, provided by yourselves as tertiary educators but in hospitals or clinical facilities in rural locations?

Ms Reilly—No. Deakin University was working in conjunction with Mount Isa for the indigenous, but I am not aware of any in Queensland. James Cook University works closely with Mount Isa, so I would suggest that they probably have some input into that centre.

Senator McLUCAS—Ms Reilly, you said in your submission that consideration needs to be given to attracting indigenous students into nursing. You go on to say that scholarships will be needed. Are scholarships the only way that we can get indigenous young people into nursing?

Ms Reilly—It is probably not the only way, but I think it will go a long way towards that, because they seem to find it much more difficult financially to do the course. In fact, we had one second year student who did not receive a scholarship this year and who was going to withdraw, and we have taken it upon the department to give her a scholarship to encourage her to continue.

Prof. Creedy—Another strategy that Griffith was bidding for was videoconferencing facilities, because we find that indigenous students complain of loneliness and lack of family connection. We were hoping that, through the video link facilities, they would be able to see their family members and have regular contact with their community.

CHAIR—How many places do you provide for ENs who want to become RNs?

Ms Nash—We do not have a set quota for that at QUT. The people who wish to do that need to apply through QTAC and so become part of the commencing group of students.

CHAIR—How many do you take? How many are you teaching?

Ms Nash—To the best of my knowledge, it is probably around 20 or so a year. I need to check that figure, but I think it is around 20.

Prof. Creedy—I would be guessing; I am sorry. I do not have that figure in my head, but I think it would be a similar proportion: 20 to 30 out of 400.

Ms Reilly—I am sorry, I do not have those figures either. We seem to have a reasonable number—whatever a reasonable number is.

CHAIR—That is a very good answer, Ms Reilly. I ask the question because the evidence across the country so far is that everybody says ENs can move to become an RN. You have told us already that if they have a certificate or a diploma, they then have a year or otherwise it is case by case. However, the ENs tell us that they might die before they get a place. There are simply not enough places for the number of ENs who would like to transfer to RN. Is that the case in Queensland on your campuses?

Prof. Creedy—I do not believe that would be the case, given that they compete through the system of QTAC. So if they have completed a diploma, they get recognised credit for that. That is not an issue.

CHAIR—The issue is that there are not enough places, not whether they are qualified. They are qualified all right, but there are not enough places. I am talking about down south—that is another country.

Ms Reilly—I would not suspect that that is the case at USQ.

CHAIR—If there is anything further that each of you could provide to the committee on that, it would be helpful. Again, it is a question of whether 100 apply but only 20 get selected, or whether they are not even pushing to apply. Could you also tell us, on notice, what is happening to the entrance scores. I have had offers from that end of the table to help me understand the Queensland system and I appreciate that. If you could you tell us whether the entrance scores are going up or down, and from where to where, that would help.

These questions are not necessarily sequential and we are running out of time, so I ask you to be brief in your answers. How do you find clinical places? Is it a challenge to find sufficient clinical places for your students? Where do you get them? Do you think there is anything to be said for a permanent relationship so that there is brand loyalty, as in 'All of our placements go through Toowoomba Hospital'?

Ms Nash—The answer to your first question is, absolutely, yes. It is an incredible challenge to find clinical placements for all of our students at the times they are required: when their blocks of clinical placement are due to be undertaken. So there is nothing more I need to say about that, except that it sends us all grey. That is an issue that has been discussed throughout the committees and one that Sue was referring to before. I will leave it at that. The second part of your question was to do with—

CHAIR—Brand loyalty.

Ms Nash—That is an interesting question. From our perspective, probably the bulk of our clinical placement goes through one clinical facility in particular, and that is the Royal Brisbane Hospital. But by no means can all of our clinical placements go through that particular facility.

In practice we use every acute care facility around Brisbane that I am aware of; every acute care and private care facility in the outer metropolitan area; we go up as far as Nambour, down as far as the Gold Coast, up to Toowoomba; and we use a rural placement in program in addition to all of that. It is a very wide area. We use aged care facilities in addition to the acute care facilities and so on. One of the issues with brand loyalty would be the fact that, for our program at least, we require that all of our students obtain placement in mental health because we believe that is an integral part of a comprehensive program. If we chose one particular facility as our brand facility they may or may not be able to supply that type of placement. So I am honestly not sure whether it would be possible to obtain all types of placement within the one facility for all students. Community would have to be taken into account, and aged care.

Prof. Creedy—How we obtain clinical places at Griffith University is slightly different because we are located on three campuses. We actually employ four people full time to devote their energies to organising clinical placements for our students. It usually commences six to eight months in advance where letters are written to the clinical agencies requesting placements. So the process occurs a long time in advance.

However, we are constantly held at the mercy of the clinical agencies. Even though we may have a signed agreement with them that they will take a certain number of students on a particular date, they can still turn around on the Friday before clinical placements commence on the Monday and say, 'Sorry, we can't take your staff.' We had a situation recently where the Princess Alexandra Hospital, which is a huge tertiary facility, did not take any student

placements in the month of March because they were moving from their old building to their new facility. That put everything into chaos for us at that point in time. That is why, like every other university, we try and get our students in any possible placement.

We have put in place some quality mechanisms; there are some placements where we do not want our students to go because they simply do not provide quality care and we do not want them to learn habits of poor practice, or they are not able to provide sufficient registered nurse supervision for those students.

CHAIR—Are you prepared to name them?

Prof. Creedy—I could provide you with a list of places that we do not support as clinical agencies.

Senator LEES—Is that hospitals or in aged care?

Prof. Creedy—Predominantly aged care but there are certainly some smaller facilities.

CHAIR—I would like to know what you, or anybody, does when you come across an institution that is just not up to scratch.

Senator KNOWLES—Also, is that evidence going to be provided in camera? Do you want that evidence to be public or would you prefer it to be confidential?

Prof. Creedy—Confidential would be good.

CHAIR—Brand loyalty or not?

Prof. Creedy—It certainly has advantages, simply because we are less likely to be treated in a dismissive way at short notice. That is certainly easier for regional universities. We have brand loyalty with the Gold Coast Hospital because we are the only place down there offering nursing. It is far more difficult in the Brisbane metropolitan area where you have five universities competing for clinical places.

Ms Reilly—Which we do in Brisbane, too. The challenge of organising clinical placements is certainly there. Our situation is very similar to that of the Gold Coast and Griffith—the way we have a full-time person who organises our placements. We do try to place our students in the appropriate placement according to the objectives for that particular placement.

The other thing that is probably worth mentioning is that each university has a clinical coordinator. They might name it differently but basically it is an academic who is a clinical coordinator. They meet on a regular basis to try to work out how not to overload the clinical areas. There are times of the year when there are probably about 1,000 students looking for clinical placements. It is difficult when we are all trying to place students at the same time but there is very good will amongst the clinical coordinators at the universities. The challenge is certainly there. Clinical placement numbers are decreasing because bed numbers are decreasing in some hospitals, and that does create a problem. For example, at the Toowoomba Base

Hospital, we used to be able to place approximately 40 students at one time. Now we are lucky if we can place 12. That is not because they do not want to take them; it is because they have not got the bed numbers in order to do that.

Senator WEST—Is it important to say that, whilst they have not got the bed numbers, their patient numbers are actually not decreasing?

Ms Reilly—Well, actually their patient numbers have decreased. They do make the point between bed numbers and patient numbers. But we are very focused on having diversity in our curriculum and, like the other universities, we have community and mental health. In Toowoomba we are in a fortunate situation in that we have a large mental health facility, one of only two in Queensland, and we have two rather large private hospitals and a base hospital. However, we could not place all our students in a particular year in those hospitals, so we do use the smaller hospitals.

CHAIR—We are almost out of time. I have certainly got a lot more questions. Can we have shorter answers or perhaps even take them on notice if they are going to be long. Do you each have a curriculum advisory committee and is there input from nursing groups as to the curriculum needs and requirements? As a sequel to that, do you have any formal partnership arrangements with the hospitals or health services, not so much about taking clinical placements as about input into the curriculum, as in: 'You are sending us all these students who are very good at A, but we need them all to be good at B'—or the other way around? Do you each have a curriculum advisory committee?

Ms Nash—Yes.

Prof. Creedy—Yes.

Ms Reilly—Yes.

CHAIR—And you do have formal arrangements about feedback into the academic course?

Ms Nash—Yes.

Prof. Creedy—Yes.

Ms Reilly—Yes.

CHAIR—What is the ratio of supervisor to students leaving your institution, when they go to clinical practice? Is it one to eight?

Ms Nash—One to eight maximum.

CHAIR—You said, Professor Creedy, that DETYA sets the numbers of nurses. If we asked DETYA about the numbers of nurses, what would they say and/or would they say it is up to the management of the university?

Prof. Creedy—They would say that they provide a best guess in terms of numbers, that there is no national data set in terms of projected work force planning figures and so they would not know.

CHAIR—That is really interesting because we have also been told that the problem with nursing is that there are just not enough students able to come through because there are not enough undergraduate places. As I think you have heard from my colleagues, there is doubt about whether undergraduate entrance is the only or significant problem. Your comments are interesting—that that is the federal government's DETYA people's best guess.

Prof. Creedy—And could I suggest that it is not necessarily university places that are the problem; it is clinical places that are the problem. We cannot take in more students because we cannot place them and they cannot complete the requirements of the program.

CHAIR—Regarding Aboriginal and Torres Strait Islander students: we have had evidence from other people that if you get non-English-speaking background people or people with other kinds of disadvantages in terms of proceeding successfully through their course, there is a lot of sense in investing in those students rather than letting them be wasted and starting again with similar students with the same problems or with different students. We have heard about some of your work in answer to Senator McLucas, but what about when the Aboriginal and Torres Strait Islander nurses graduate? Do you see that there is extra assistance to them in their first or second clinical years? Or is that no longer your baby?

Ms Nash—That is pretty much it. They become an employee of the health care facility.

CHAIR—This has probably been asked but I would just like to run it again. A number of other witnesses have said that university students have to earn to get through their course—they are all out flipping hamburgers or pulling beers or something—but there is a case for them to actually work in paid work in hospitals, usually, it was proposed to us down south, more at the EN than the AIN level. I wanted to ask you this again, simply in terms of your comments about the Nurses Union not being comfortable with that. If the students were working part time to increase their clinical experience and being paid at some very modest rate— we understand usually at the AIN rate—is that different from what you were answering before, particularly you, Professor Creedy? Would the Nurses Union, as you understand it, object to students working during their vacation as AINs in a hospital?

Prof. Creedy—I do not believe so.

CHAIR—So that is separate from what you were saying about a program to allow AINs to be working during their course?

Prof. Creedy—That is correct.

CHAIR—So this would effectively be saying: 'Working? Okay; but it is outside of your academic year.'

Prof. Creedy—The proposed model was that students would predominantly do their clinical placements at that agency in order to feel familiar with, and to have that sense of belonging to,

the clinical organisation. The paid work that the hospital was proposing would be outside of university time, and so it does extend beyond that.

Ms Nash—There is an issue, though, about whether the student would be employed as an AIN, in which case they would be expected to fulfil the role of a AIN and only accept responsibilities which are consistent with the AIN role—as compared to being employed in some other, perhaps student related or similar capacity, in which case there is a really important question about what the expectations of their performance would be, what the level of supervision would be that would be provided by the employer, and how there would be clarity about what the person could do and could not do in that capacity. That is—from my conversations at the moment—a bit of an unclear area.

Senator WEST—There are legal implications there, too, aren't there?

Ms Nash—That is right.

Senator WEST—Big legal implications.

Ms Nash—Yes, exactly.

CHAIR—Down south we have heard about some people who have moved their courses to having near enough to 100 per cent clinical experience in third year so that, as they come out or when they start working as a first year RN, they can 'hit the ground running' or at least they would be better fitted for that. Is there any move in your courses towards increasing—except for you, Professor Creedy, because you have cut back—the number of hours of clinical experience?

Ms Reilly—We do not plan to at the moment. We have a five-week block at the end of their final year, basically in a setting of their choice.

CHAIR—And you said about eight weeks?

Ms Nash—That is right. We are not looking to increase the number of total hours across the course, but we have ramped up the number of weeks that they spend in their clinical placement in the final semester. Our feedback from employers is that this is a good move.

CHAIR—You actually refer to research in nursing at the University of South Queensland, and I am particularly pleased to see that—just indicating my preference or prejudice to start with. I would like to ask each of you about research in nursing. But what is clear from today's session is that so much of the focus has to be on giving the undergraduate students the adequate theoretical and practical knowledge to actually go and work in an applied way. What capacity or room is left for research? Up until fairly recently nursing has taken a terrible belting because you did not have any sort of significant theoretical research background et cetera. In 30 seconds each: Ms Reilly?

Ms Reilly—In the undergraduate program?

CHAIR—Just in the nursing research in your faculty; this is your professional academic—

Ms Reilly—We have just established a centre of rural and remote health, and it is run by a professor from our department, the Department of Nursing. It is focused mainly on nursing research but we are wanting to include other disciplines as well. Basically anybody is encouraged to work through the centre to carry out research, but with more of a focus on rural and remote nursing.

Prof. Creedy—Griffith University has been functioning for the last 11 years, and our main orientation has been to enable our staff to be doctorally prepared. So by the end of this year, 70 per cent of our staff will have PhDs—which greatly increases our research capacity, not only to conduct research but also to provide supervision for research higher degree students, whose numbers are also low proportionally across the university. Griffith established our very first centre this year, which is the Centre of Practice Innovation in Nursing and Midwifery. I have been appointed as the director of that centre. But primarily our focus has been on completion of PhDs and the establishment of track record through publications and research, but also linking into the big-name researchers who do attract ARC and NHMRC funding: currently nurses do not get a look in, because we do not have the track record.

Prof. Yates—And it is the same with the research profile in nursing, which has really grown dramatically in the last few years. At QUT, we can say we are competitive. We have NHMRC grants and ARC collaborative grants. So we are starting to compete with the traditional disciplines. We have close to 40 PhD students at the moment. While most of those have come in and are studying part-time, we are now actually seeing a very different cohort coming in. They are the younger people, who are newer graduates, who see themselves as having a research career in nursing, and they are getting the scholarships to study and do their PhDs full-time. So I think that we are going to see a dramatic change in that area over the next few years and that nursing research, the sort of research that nurses are doing, is patient focused and patient-outcome focused. So I think it is going to contribute a great deal to health care as well.

CHAIR—Thank you very much for that information. I am very pleased I asked the question. I would have to say in closing that as first-time witnesses you should take a bow.

Proceedings suspended from 12.45 p.m. to 1.18 p.m.

FOX-YOUNG, Dr Stephanie Kay, Acting Executive Officer, Queensland Nursing Council

NESVADBA, Ms Cathleen Elspeth, Coordinator, Nurse Education, Queensland Nursing Council

GENDEK, Mrs Marilyn Ann, Chief Executive Officer, Australian Nursing Council Inc.

RAVEN, Ms Leanne Kaye, Chairperson, Australian Nursing Council Inc.

CHAIR—I would particularly like to note our appreciation of the ANCI coming all this way to assist us when we re-arranged and organised our witnesses. Thank you for that. 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 the committee will give consideration to your request. I need to remind you that the evidence given to the committee is protected by parliamentary privilege and any false or misleading evidence could constitute a contempt of the Senate. The committee has before it your submissions Nos 926 and 887. Do you wish to make any alterations?

Dr Fox-Young—No.

CHAIR—I will ask each of you now to make a brief opening statement and then field questions. Could we start with the ANCI?

Mrs Gendek—The Australian Nursing Council Inc welcomes the opportunity to appear before the Senate Community Affairs References Committee inquiry into nursing. Australia, like many countries, is suffering from major nursing shortages and this is having an effect on the quality of health services. The council was established by the state and territory nurse regulatory authorities to lead a national approach with them in the development of standards for statutory nurse regulation. The membership of the council consists of all of the state and Territory nurse regulatory authorities and includes two public members.

Some of the council's objectives are: to identify matters which impact on or are relevant to statutory nurse regulation; to undertake assessments of overseas qualified nurses consistent with the registration and/or enrolment requirements of the Australian nurse regulatory authorities; to develop and be guided by a strategic view of statutory nurse regulation in the national and international context; and also to foster cooperation, consult with and provide advice to government bodies, professional and other organisations, and international nurse regulatory authorities.

The key role of the ANCI is the development of standards for the regulation of nursing in Australia from a national perspective. A key example of this is the national competency standards for registered and enrolled nurses which are developed and maintained by the ANCI. These standards are adopted by all the nurse regulatory authorities as the core standards which indicate the scope of nursing practice, and which all nurses must be able to demonstrate.

The ANCI also conducts other projects that contribute to the maintenance and development of national standards and to the development of international standards. As well as the competency standards, some of these others have included a code of professional conduct for nurses in Australia and a code of ethics for nurses in Australia, which was developed in collaboration with the Australian Nursing Federation and Royal College of Nursing Australia. It has established a collaborative advisory panel of the Australian and New Zealand nurse regulatory authorities to address issues concerning the recognition of nurses educated outside Australia and New Zealand. It provides and resources the secretariat for the biennial meetings of regulatory authorities in the Western Pacific and South-East Asian regions and it has established a memorandum of cooperation with the Nursing Council of New Zealand.

The ANCI proposed a number of recommendations to the inquiry last year when it called for submissions. These centred on the need to establish effective national data collection systems, key matters to be addressed in relation to nurse education and the entry of nurses to the work force. It was stated in the submission that the nursing work force is at the core of health care provision in both the public and private sectors in this country. It is widely acknowledged that the supply of skilled and experienced staff was not meeting current demands for nursing services. This is a key issue from a regulatory perspective when lack of staff and an unskilled staff mix undermine the effective and safe delivery of health care by nurses who are accountable for their practice.

The transfer of education for registered nurses to the higher education sector occurred between 1985 and 1993. This was a result of many years of action taken by the profession for recognition that hospital training for registered nurses was no longer appropriate, and the rationale for that transfer is still relevant today. However, ongoing development of nurse education must continue, including consideration and funding for an appropriate program to adequately prepare graduates, and mechanisms for transition to the work force for all graduates.

It is also noted that the committee is to make recommendations on nurse education and training to meet future labour force needs, the interface between universities and the whole system and strategies to retain nurses in the work force and to attract nurses back into the profession. The inquiry and the government's national review into nursing education are addressing similar concerns, focusing on the interface between education and the service provider. However, it is of concern that there will be a balance of focus between both areas, and not just a focus on education.

Structural work force changes are integral to the retention of nurses, particularly where professional preparation has advanced and responsibilities have also increased. Structures and policies in the health industry currently may be adverse to the expectations of nurses, who have been prepared for a professional role. Issues that weaken the scope for nurses and the health industry and that also weaken the effective and safe delivery of care that need to be considered include workplace culture, management practices, leadership, other legislation within the state and territories, fundamental issues of the health system, as any educational improvements and strategies to recruit and retain nurses will be ineffective, and financial resources to maintain a quality nursing work force that meets the health needs of the community.

To complete this opening statement, I will briefly touch on two of these issues that were not addressed specifically in the ANCI submission to the inquiry. The first issue is leadership. This

has been raised as an area of concern for the future. At the individual level the lack of opportunity for and development in nurse leadership has resulted from a paucity of positions for nursing leaders. They are often subsumed into generic management roles. It is the view of the ANCI that a key development for leadership in the clinical arena is the nurse practitioner. Therefore, positions for this role should be widely supported by health care funders, both public and private.

Professional leadership in nursing and policy has been shown through the effort of professional groups developing collaborative models for effective leadership. This has involved the establishment of various peak groups or advisory groups to progress policy development consistent with the philosophy or intent of the groups. By way of example, the ANCI has established a professional reference group which consists of representatives of key national organisations.

The ANCI also holds the position that this model can also enhance effective policy development for the Commonwealth government and that a nursing presence at the executive level in the Commonwealth government should be established. It considers the contribution of a national nursing perspective to the health policy process is integral to effective health outcomes for the community. Nursing leadership advice and contribution to Commonwealth government policy and initiatives would not only enhance policy decision making in areas such as health work force and education but also assist in and coordinate implementation of relevant policy. I have a copy of our position statement on this matter which is provided for the information of the committee.

The second and final issue to raise is concerned with other legislation within states and territories. From time to time, calls are made by various groups and individuals for a national regulation system for nurses to be established, that state and territory regulatory mechanisms be abolished and replaced with a Commonwealth registration board. This is often associated with the view that such a system would facilitate easier movement of nurses around the country and prevent barriers to practice.

Statements are made that nursing acts are vastly different from each other and that the barriers are the authorities which administer the acts. Currently, there are more commonalities than differences between each of the nursing acts. The differences lie in the margins. What is not often taken into consideration are the objectives of the acts and the policies than can be developed from the powers of the acts.

However, more importantly, other very pertinent legislation under which nurses function hold significant differences between jurisdictions—for example, legislation related to drugs and poisons. Any attempt to establish a national system of regulation requires that all legislation which impacts on nurses' practice be considered. In addition, any differences in legislation or policies have not generated difficulties in moving between jurisdictions under mutual recognition legislation. The processes involved provide for an almost instant recognition of nurses moving from one jurisdiction to another.

When the ANCI was established, Commonwealth legislation was proposed but not supported. However, the ANCI, with the nurse regulatory authorities, has undertaken, or is undertaking, a number of key actions to facilitate a national approach to regulatory standards which enhance

the practice of nurses and, importantly, are in place to protect the public. These include the development competency standards, as I said. I would like to just point out that we have been giving consideration to the development of national standards for nurse practitioners. This work will be undertaken in collaboration with the Nursing Council of New Zealand.

Another key area is continuing competence. The ANCI commissioned some research in relation to identifying indicators of continuing competence. Two principles arose from that which have been adopted by the nurse regulatory authorities. Another area is professional conduct. All nurses are bound by the ANCI Code of Professional Conduct, and the code refers to competence and specifies that competence should be maintained. However, we are also establishing a mechanism for collecting and analysing data on professional conduct issues. The purpose of this project is to provide a national perspective on professional conduct trends which in turn will inform standards development.

Another key area within the regulatory arena is accreditation. Currently, each nurse regulatory authority is responsible for the accreditation of nursing courses in their jurisdiction. However, there has been some discussion regarding the potential to develop a national system of accreditation. The ANCI has planned a project to examine an approach from a national perspective to the accreditation of nursing courses.

As I have already mentioned, the ANCI is involved in the harmonisation of recognition policies because of its function of assessing nurses who come from overseas. This has been done through the collaborative advisory panel. The ANCI is also using the work that it has done and the resources that it has to assist in the fostering of international standards throughout the Western Pacific and South-East Asian regions through the regulatory meetings that are held.

As stated in the submission to the inquiry, problems associated with the shortage and education of nurses are more directly related to other factors than to statutory regulation and the public interest.

Dr Fox-Young—On behalf of the Queensland Nursing Council, I am not sure I can add too much to what my colleagues from the Australian Nursing Council have said. The only thing I would like to emphasise is the council's position, consistent with its philosophies and values, that any outcomes recommending change from such a committee as this or from the National Review of Nursing Education need to be based on evidence, properly funded, carefully evaluated and developed in partnership with all of the stakeholders. I think if that is done we can achieve an excellent result.

CHAIR—Evidence, funding, evaluation and collaboration. If brevity is the soul of wit you are an extremely witty person, Dr Fox-Young. The committee is enormously appreciative.

Senator KNOWLES—I would like to ask the council to expand on what it is suggesting with regard to the National Nursing Workforce Advisory Committee.

Dr Fox-Young—Which council?

Senator KNOWLES—Sorry, I mean the Queensland Nursing Council.

Dr Fox-Young—I believe that that is something that the council recommended based on its work with the Queensland Health Ministerial Taskforce, which I imagine you would have heard about this morning from Queensland Health in greater detail than I would need to go into at the stage. There seems to be a lack of good data in terms of work force planning for nursing. Queensland has been doing a lot of work through the ministerial taskforce to look at its own needs and requirements and planning longer term. A similar kind of structure where universities, health agencies and others are working together to try to predict the needs of nursing into the future and to predict health care needs must be established at a national level.

I believe that the Australian Institute of Health and Welfare is, at this moment, developing a work force data collection strategy. I was involved in a meeting about that a month ago. It will be the beginning of the kind of data collection that needs to be done, but more needs to be established in terms of a group that can guide that data collection. Groups from across Australia are needed with the kind of expertise that can identify areas of emerging need and identify changes that are occurring within the work force so that action can be taken. With any kind of university course you have a long lead time in terms of making changes. If you predict that you are going to need more nurses, it will take at least three years to get them. If you try to increase the intake now, you will not have an increase in nurses for another three years, certainly not registered nurses.

Senator KNOWLES—Does that link in with your suggestion concerning the Commonwealth chief nurse coordinating that development or does that position go further than that which you have just described?

Dr Fox-Young—The Commonwealth chief nurse position is one that the council believes would have a valuable role in that group. It would also have a role beyond that in terms of being a conduit for policy advice to the federal government, which currently does not exist within the structure of the health department. However, that chief nurse position would need to be properly resourced and would also need to be properly supported by an advisory council that could feed into it the profession's desires and aspirations so that the chief nurse is not an individual trying to do everything.

Senator KNOWLES—Do you worry about some of these proposals getting top heavy: everything comes from above down, rather than the trickle system working in reverse?

Dr Fox-Young—I imagine that that would be possible. I am sure that a powerful structure such as that could be developed. I would hope that the kind of structure that the council was proposing would not be such a top heavy organisation, that it would have the kind of advisory capacity and consultative capacity that would enable it to function effectively.

Senator KNOWLES—I do not know whether you were here earlier this morning when I was explaining my concerns to other witnesses that Canberra would impose its wishes on the states as opposed to the states having adequate input to say, 'This is what we need, this is the best for this state, it might not be the best for the neighbouring state or the next one.'

Dr Fox-Young—Certainly that is a risk. I noticed that Senator Crowley mentioned that down south was different—they seem to think that up north is different. Queensland is different; we are a much more—

Senator KNOWLES—In the west we know the east is different.

Dr Fox-Young—We are a much more disseminated population. There is a greater proportion of population in the rural area and a greater proportion of nurses in the rural area than elsewhere in Australia, so the needs of nurses are often quite different in terms of access to education, access to continuing education, for instance. The technological advances are obviously improving that, but there are still some difficulties. So, yes, it would be important that such a body did not become totally centralist and that states continued to have the opportunity to put their views forward and to have them taken seriously.

Senator KNOWLES—While on things national, I suppose I really should just touch on the question of the national registration scheme and also a national curriculum. I live in sheer wonder why we still do not have a national curriculum in schools, let alone in universities, with such a transient population now. I would like to hear from both organisations what your views are on both those subjects.

Mrs Gendek—I will start with the national curriculum first, if that is all right.

Senator KNOWLES—Fine.

Mrs Gendek—In the eighties we developed the national standards which all nurses must be able to demonstrate in order to be able to practise as a nurse, which is the competency standards. From that perspective, national standards still exist. When nursing courses are accredited, these standards are used to identify that the course would be able to produce a graduate who could in fact demonstrate those competencies. So, in essence, national standards exist for the development of courses, standards which everybody has adopted for that purpose. I think you are talking about a course—one course—that everybody uses across the country. Is that what you are talking about?

Senator KNOWLES—I am talking about it in the context in which your submission, I think it was, referred to it—as a national curriculum framework.

Ms Raven—I can probably add to that. In terms of the council's consideration of this area, we have recently decided that we need to look at a national accreditation system. We think that that would bring a better sense of standards being met across the country—and I will pick up on a couple of areas that have been mentioned this morning in the evidence that you have received. There were a few questions about standards in relation to clinical placements for students in courses. Currently we know that those standards are different—slightly, or marginally—across the country, depending on which nurse regulatory authority is looking at this course. If we could have a national standard in relation to that, I think it would be of great benefit.

The other area is particularly the processes that universities have in place. These accreditation standards could set the platform for national processes—for example, the processes they use to ensure that they have employer input into the review of their programs. So it is our thinking that, if we were able to achieve some sort of national accreditation standards all the states could agree with, this could be done quite easily without legislative change within the relevant states. It would basically mean that we would have to work in partnership with all the regulatory

authorities in the states and, if everyone were happy to commit to whatever is agreed, we would not require any legislative change. It would also create—

Senator KNOWLES—Who is going to be the broker in all of that.

Ms Raven—The Australian Nursing Council is leading this issue.

Senator KNOWLES—Would you be the broker to get all those parties together to come up with a solution?

Ms Raven—Yes, around the council we have representatives from all the nurse regulatory authorities in each state and territory. We operate in that way in terms of partnership with those bodies, and it is on our strategic agenda to look at it. At the moment, there is a commitment from all the states to progress it.

The other side of the national standards issue is in relation to developing some sense of knowledge about what is happening with the national work force and what is happening through DETYA with the funding of education programs. Our thinking at this point in time is that, if we can get some national standard for accreditation of courses that will make a tighter link between the funding through DETYA and the work force platform that we have put forward through the council, we think there should be a Commonwealth government nurse position and a directorate set up that should have as part of its role some link into the national work force area.

Dr Fox-Young—From the Queensland Nursing Council's perspective, the idea of a national curriculum is one that brings back some memories of blueprints for nurse education that our predecessor, the Board of Nursing Studies, had. One of the things that occurred as a result of those blueprints was a stifling of innovation and very much a conformity within the education of nurses for some years in Queensland. We believe that it is much more important to allow that sort of innovative development to occur and for that to be properly evaluated so that there can be some identification of best practice and use of that in different settings, because again it will depend on the kind of university that you are operating in, whether you do have distance education areas within your course, how you deliver your course. Innovation is something we would not like to see stifled by a national curriculum. I believe that the idea of having national accreditation standards would be much better.

We also have completed a systematic review of undergraduate curriculum transition processes and undergraduate clinical education which reached the conclusion that there is as yet not sufficient evidence to say what is in fact best practice in curriculum development for nursing, nor for that matter for health professions generally, because they looked not only at nursing education but more widely at other health professions as well. We found this very sad because we were hoping that that would be an outcome from the systematic review. It means that there will need to be more work done. If that work is not taken up as a result of the two inquiries that are going on at the moment, the Queensland Nursing Council has already established a select committee which is temporarily on hold until the outcomes of these two inquiries are known. We will move forward with our own work if necessary if it does not occur at the national level.

CHAIR—Before I call the next senator, can I ask whether you two talk agreeably to each other.

Ms Raven—Yes.

Dr Fox-Young—Yes.

CHAIR—In answer to Senator Knowles's question, aren't you saying, Queensland, that you are not quite in agreement with the AN—

Dr Fox-Young—No, I said that I believe that the most appropriate way to go is to have national accreditation standards—

CHAIR—But that do not stifle innovation.

Dr Fox-Young—I do not believe that will. I think a national curriculum could.

CHAIR— Thank you. I am glad I got that point of difference cleared up.

Senator LEES—Just to pick up some comments you made in your opening statement, in the summary you related the issues back to funding. What level of funding would you suggest, but in particular what are your priority areas? What are, say, the top three places to which funding should go?

Dr Fox-Young—I am speaking as the executive officer of a regulatory authority, so I am actually speaking a little outside my area of expertise here. I believe that there are great needs for support for clinical placement for students in undergraduate and postgraduate specialist courses. I believe there is need for an examination of the funding levels for the new graduates of programs. It is not so much that they are not prepared for the work force necessarily; it is often that the work force is not able to support them in the way that they need to be, mostly because they have limited time because of the acuity of the patients and the throughput of the loads that they are dealing with in terms of health care at the moment. If we got those two funded well, I think we would be on the right track. There is also the issue of retention of nurses, but that is linked into the workload and the funding to ensure that there are sufficient registered and enrolled nurses to provide the services that are necessary.

Senator LEES—Do you take an interest in, right across the board, those that come on as completely unqualified? Is that within your bounds through certificates; through enrolled nursing and then into the graduate and postgraduate programs?

Dr Fox-Young—The Queensland Nursing Council actually only enrols nurses or registers nurses. We do not have a role in any regulation of assistants in nursing or—

Senator LEES—So the assistants are not part of your—

Dr Fox-Young—They are not part of our role except inasmuch as our scope of nursing practice decision making framework actually establishes a delegation relationship between registered nurses and assistants in nursing and other unregulated carers in terms of, if they are being delegated nursing activities, a registered nurse must do that delegation and must ensure proper supervision.

Senator LEES—It is just that we have heard from other witnesses that there seems to be an almost regular practice in parts of the Queensland Health system where people off the street, who become known as POTS, as I understand it, can literally, even if they are not 18, find themselves a niche and because there is basically no-one around to take on duties that one would have thought would have at least required an enrolled nurse. Is this something that you are aware of, concerned about?

Dr Fox-Young—It is something that we certainly are aware of. We receive a number of calls from people who are either being asked to supervise such people as registered nurses or who are fearful that they are going to be replaced by such people in some workplace settings or the people themselves who are being asked to do things that they do not feel comfortable to do.

One of the reasons we developed our scope of nursing practice decision making framework was to try to address that issue. We have spent a considerable amount of time and effort in educating registered nurses. We have invited unregulated carers to come to those sessions. We have also spent a fair bit of time working with employers in terms of the kinds of activities that it is legitimate to ask such people to do. We are not saying that registered nurses and enrolled nurses have to do everything in terms of caring for people but we are saying that, where there is a health and nursing component, it must be done properly through delegation and supervision by registered nurses.

Senator LEES—Should we actually be regulating this—I understand there is a certificate system as well for attendance—to insist that at least the first level or the second level is acquired?

Dr Fox-Young—That is an issue that the profession is certainly grappling with and I am aware that, in Victoria, they are probably further advanced than we are in Queensland in terms of the need to regulate that group. It is a call that we have had in the past. Our legislation does not enable us to regulate them and it is something that we believe that, with the work we have been doing with the scope of nursing practice, we have not completely—but have to a great extent—addressed the matter. If there was a call or a decision to regulate such groups, you would need to be careful about how you regulated them. Regulating by title—that is, if you are going to be an assistant in nursing, you have to have X, Y and Z—would probably mean that some unscrupulous employers would start calling them something else.

CHAIR—That is the case now, isn't it, Dr Fox-Young?

Dr Fox-Young—It is true.

CHAIR—Isn't it your business to chase them out?

Dr Fox-Young—There is also the issue in terms of what happened in the 1970s in Queensland when there was a grandparent arrangement that allowed people who were currently assistants in nursing to become enrolled nurses, if they were recommended by their directors of nursing, on the understanding that the assistant in nursing would disappear. That has not happened.

Senator LEES—Are there any comments on that before I pass on to my colleagues from the national body?

Ms Raven—I would just like to follow up on Stephanie's comment about the Victorian situation as I am the chief executive officer of the Nurses Board of Victoria as well, although not here speaking on their behalf today. We have seen through the Australian Institute of Health and Welfare's collection of data in this area—I believe we have provided some information in our submission on that—that the number of unregistered health care workers is increasing.

In Victoria the Nurses Board has taken the view that there should be some licensing arrangement organised and put in place by the state government. Its view at the moment is that, if it were to sit within any health professional regulatory arena, the nursing profession would be the most appropriate.

Senator LEES—Thank you.

CHAIR—That is very restrained, Ms Raven. Let me ask you or Dr Fox-Young a question. Why do you not recommend to whomever that the regulations be changed—you being the Queensland Nursing Council?

Dr Fox-Young—As I said before, the Queensland Nursing Council took the view that our scope of nursing practice would address the issue.

CHAIR—And then what?

Dr Fox-Young—We would monitor to make sure that it was not getting out of hand again or so that it was not becoming obvious that there was a need to regulate. The council itself is very aware of the need for anybody who is providing a health service to be properly educated. The council has not yet taken a position on this but could very well. One of the things that they plan to do is to have consultation in the area of a whole range of things, one of which would be this.

CHAIR—It just sounds like deferring of action, deferring of decision, Dr Fox-Young. You know it has to be done; why are you not taking it up?

Dr Fox-Young—I would argue that, while our own act is currently under scrutiny in terms of the national competition policy as to what can and cannot be regulated, it might be difficult to argue that another group should be regulated as well. It is not something that we are averse to doing. Once that is sorted out, it may be something that we need to do.

CHAIR—Both of you have said that national status—whatever that exact word is—would be a good thing. Ms Raven, you have just told us what we already know and that is that Victoria is well in advance on this issue. It reckons AINs should be covered. If one person starts behaving independent of the rest, do you then determine that everyone should catch up with Victoria?

Ms Raven—We have had this situation occur quite often when different views are expressed. That is particularly something that we encourage, in relation to what Stephanie was talking about with innovation; we are all, as you would appreciate, not going to agree on particular details at the national level in all instances. What we try to do—if I could just say from the

Australian Nursing Council perspective—is come to agreement in terms of principles. At the moment, we are working with a position statement which is in draft form on the unregistered or unlicensed health care worker that we are trying to get some agreement on.

CHAIR—I am making a hypothetical case here. I have some elderly relatives living in aged care institutions and I am very angry now that I have discovered that they are being looked after by AINs and POTS. I want a nurse to be looking after them. Can I complain to you and do you act on my complaints?

Ms Raven—Most nurses boards do not have any jurisdiction to look at anyone's conduct other than those that are registered or enrolled. But most of the states have other legislation with health service commissioners in place. I think that is in place in the majority of the states and territories around the country where users of health services can make complaints or raise those issues with those bodies.

CHAIR—Should I therefore bring a complaint to you by suggesting that the senior nurse in my nursing care institution is not employing only qualified staff?

Ms Raven—Yes, certainly. That would be something that a nurses board would look at.

Senator WEST—On page 8 of your submission, you talk about quality and safety of care related to the practice of some employers who inadequately and/or inappropriately staff facilities, forcing nurses to compromise professional standards of care. You also talk about the fact that currently legislation only permits action to be taken against the individual nurse and not against health service providers. Just what is the council doing about this particular issue? Are you getting unanimity of agreement amongst your affiliates to talk governments at various levels into taking some form of stronger action against these sorts of employers?

Ms Raven—Marilyn Gendek mentioned that we were looking at collecting some national data in relation to professional conduct issues around the country. We have had one recent workshop at which we looked at getting some information together. So we are at that stage of action in relation to those issues.

Senator WEST—So it seems it will be some time yet before we can expect any action to be taken against those unscrupulous employers who take the definition of a nurse, particularly in the Aged Care Act, fairly literally, and who are skating fairly close to the wind in terms of their accreditation. There is nothing to prevent them moving from facility to facility and remaining bad employers or bad providers of quality care.

Ms Raven—One of the key issues that we see that impacts on nurses practising in that area is the drugs and poisons legislation in each of the states. There is such variance that it creates problems for nurses and for the quality of care, I believe, in those residential settings.

Senator WEST—What are you doing to ensure that these discrepancies and variations are being overcome, improved or cease to occur?

Ms Raven—Marilyn might want to comment on that, but from a state perspective we are working with the state government in relation to getting some consistency in the drugs and poisons area.

Senator WEST—That is fine; Victoria is doing that. But what are you doing to ensure that there is consistency between Western Australia, Tasmania, Victoria, New South Wales, South Australia, Queensland, plus the two territories—and maybe New Zealand as well—now that you are getting closer cooperation there and it is becoming our seventh state?

Mrs Gendek—We are aware that there has been some work done through the government in trying to get that matter of drugs and poisons in some kind of alignment, including across the Tasman. However, what happens is that there may be some decision made around a particular area in relation to drugs and poisons at that level, but it is implemented differently within each of the states and territories. What I think you are probably suggesting is that there may be scope for us to monitor that sort of activity and to ensure that we do get the consistency that we need in relation to those acts around the country.

Senator WEST—I am registered in the ACT; therefore I have the right to take my registration elsewhere. I did not train in the ACT; I trained in New South Wales. With respect to recognising the qualifications that we have gained, you have different standards or requirements that operate in each state. With respect to RNs in particular—because they are the ones who handle most of the drug and medication work—aren't you just increasing the pressure on them as they change states to actually have to ensure they are full-bottle on the variations that operate in each state so that they are not breaking the law?

Ms Raven—That is an excellent point. We are saying that there are differences between the poisons and drugs regulations in each state that fall outside the jurisdiction of particular nurses boards within that area, and they are the responsibility of state governments.

Senator WEST—What are the nurses boards doing to ensure that those whom you register are able to cope with that particular variation?

Ms Raven—I think you would need to look at our national standards in terms of the code of practice, the code of conduct, the code of ethics and our competencies. Those standards make it very clear that every individual nurse has a responsibility to make sure that they are aware of the legislation and policies impacting on their professional practice within each area. The Australian Nursing Council has been most progressive when you look at the development of a position in terms of national standards and when you look at what the other health professional groups might be doing in getting this national framework together.

Senator WEST—That is fine, but let's not get hung up on what the other health professional groups are doing. If nurses are leading the way, don't sit still and wait for the others to catch up. What are you doing to promote the fact that there need to be some national competencies there that are not there at present and to get the states to look at this particular issue?

Mrs Gendek—I will pick that up, if you do not mind. As I said, I understand your point. There is perhaps scope for us to look at a range of other pieces of legislation which are going to have some kind of impact because they operate differently within each state and territory. There

is quite a range. It does not stop at just drugs and poisons; it goes across a whole range of legislation. The medical profession certainly encounters the same issue in terms of their ability to practise across borders. There is a whole range of legislation out there that may need to be looked at in light of what you are proposing.

Ms Raven—One of the main barriers to dealing with these issues from a national federal level is the lack of a Commonwealth government nurse to close that link between the government, the profession and the regulatory body. You have that presence at a state level—three groups working closely, prioritising issues in terms of their own jurisdictions. That is not happening at the national level.

Dr Fox-Young—We also have to take account of the fact that we live in a federation of eight states and territories. We work towards having harmonisation of things that we can control, but there are things that are different and that need to be taken account of. One of the major differences in the health, drugs and poisons area at the moment is that in Queensland nurses who work in remote isolated areas can now be endorsed to give a range of medications under a drug therapy protocol. Similar changes have not occurred in the health, drugs and poisons regulations elsewhere. They have done work in New South Wales and Victoria and other places along the lines of a nurse practitioner model, and that has not happened in Queensland because there were different needs at the time.

Senator WEST—Or the doctors were putting on more pressure.

Dr Fox-Young—The doctors were quite positive about nurses gaining the right to supply medications in isolated practice. Doctors were among the greatest supporters of that, particularly doctors who work in remote areas. The nurse practitioners may be different.

Senator WEST—Some doctors do not like them in New South Wales. Can I just turn to your national body's concerns about enrolled nurses. On page 12 of your submission, you say that you are conducting a project examining the role and function of the enrolled nurse and the revision of competency standards and that you expect the results of the work to be available towards the end of the year. Is that available?

Mrs Gendek—Yes, I can provide the committee with a copy of that report.

Senator WEST—That would be lovely.

Mrs Gendek—It is just about to be published and distributed. I will give you a copy.

Senator WEST—How much of a problem are the differing standards that apply to ENs state to state and the different programs they actually undertake?

Mrs Gendek—Somebody wanting to be an enrolled nurse would have to undertake a program that had been accredited by the nurse regulatory authority in each state and territory. However, there are differences in the award. In Queensland, the award is a diploma and in the other states and territories it is a certificate IV. I understand that in Western Australia the certificate IV is not supported at this stage. They did have a diploma—by whatever name it was at the time—and I think there is pressure on to revisit that. Like the Queensland course, it is an

18-month course. There are some differences. However, with the enrolled nurse competency standards, a course must basically prepare a graduate to be able to demonstrate the competency standards. At this point, it may be that some of the courses we have now are probably preparing graduates to more than meet those competency standards.

Senator McLUCAS—I think that actually goes to the question I wanted to ask, and there is only one: on page 14 of your submission, the recommendation says that we need accreditation standards that:

... ensure that the quality of clinical education is consistent with the ability of the students to meet the competency standards ...

I am just looking for clarification. Perhaps you could explain to me what you mean by that, and then I will ask the question.

Mrs Gendek—Certainly, Senator. At the time we prepared the statement there were probably a number of recommendations within the submission which would lend themselves to the statements we made earlier about this accreditation framework. There was another recommendation prior to this one which talked about the need to continue to have an accreditation of programs by a body that was involved in the regulation of nursing. This particular recommendation is another part of that. A component of actually accrediting a course is to identify that the clinical education is consistent with students being able to demonstrate the competencies. If there is no clinical component to the course, it is unlikely that the students would be able to demonstrate the competencies. Perhaps we can look at the issue of what is the minimum for them to be able to do that, if that is an issue in terms of being able to get clinical placements. However, I am not saying that is the answer; I am saying that that is generally what that is referring to, as part of that overall accreditation.

Senator McLUCAS—That clarifies it, thank you.

CHAIR—We were talking about quality and you mentioned that if there were differences in quality it would be a concern to you. I was not sure whether you meant a difference in quality between states or within states. It referred to clinical placement. I am not sure whether it was Mrs Gendek or Ms Raven who was talking. I decided not to interrupt—it was way back when you first spoke. Let me put it this way then: do you know of significant differences in quality of clinical placement or teaching between states?

Mrs Gendek—I do not know of any specific ones that have been brought to my attention. I did mention quality; but I was talking more about—if you are referring to my opening statement—quality of care and issues surrounding the ability of a nurse to provide quality care and how standards may be compromised if the infrastructure is not there for them to be able to do that.

CHAIR—I recall it was Ms Raven who said, 'I heard earlier evidence about placement in places where the quality is not good.' Do you remember? Earlier witnesses talked about some places. The professor from Griffith said that there are some places where nurses may reluctantly have to be placed because the quality is not good enough. And you said, 'Yes, that is a matter of concern when there are differences of quality.' I wanted to know whether that was within states

or between states. If I graduate in Tasmania am I as good as I would be if I had graduated in Adelaide?

Senator WEST—It used not be 20 or 30 years ago because Tasmania had three-year training and the rest of us had four years, so when they came to New South Wales we put them on a lower salary level for 12 months.

Ms Raven—One of the benefits we have found in the regulatory area in terms of making these comparisons between courses—whether they are courses in one particular state or courses in other states—has been the development of the competency standards.

CHAIR—That is true. In light of all of that, do you know of major differences between one institution and another such that you would say to universities, 'Do not send your students there; they are very poor and they won't learn well'?

Ms Raven—I know of a number of universities that have what you would call a black list, which Professor Creedy referred to this morning, of health service facilities that they have found problems with in terms of student placements.

CHAIR—Is that brought to your attention?

Ms Raven—In the accreditation process, yes; we gather information about the facilities that they are using.

CHAIR—What do you do with that information?

Ms Raven—I am not aware that we have asked universities to provide information about the facilities that they would not use.

CHAIR—Information is provided to you that absolutely and beyond any doubt institution X in state Y is hopeless; what do you do about it?

Ms Raven—I can use an example from the aged care area. In our accreditation process we access the public reports of the people who go in and monitor the standards of nursing homes. We use that information when we have applications for people to conduct programs in these areas, and we use it in the accreditation of course processes as well.

CHAIR—Do you actually say that nobody can go there until they get their standards up?

Ms Raven—No, we do not. We are looking at courses; that is our focus.

CHAIR—Well, this is a course. This is a placement from course Y.

Ms Raven—If we were aware that—

CHAIR—You are. I have told you.

Ms Raven—a nursing home was not meeting standards, we would raise that. If a university put forward a course which used that placement area, we would raise that in our accreditation review.

Senator WEST—What do you do when you get that message? What do you do to ensure that the RNs and the ENs that are working there are working to their level of competency? Or do you just dismiss it and say it is the responsibility of the employer and administrator? You do have a responsibility, a duty of care as the regulatory and registering body in your individual state, to ensure that those nurses are practising at the levels of competency that are required, so what do you do?

Dr Fox-Young—On behalf of the Queensland Nursing Council, there would be a number of things that we would do. We cannot investigate anything unless we have a complaint about an individual. It is in our legislation that it needs to be an individual nurse who is reported. If it was reported to us that an individual registered nurse in that area—whether it was the manager or the employer—was inadequately resourcing or staffing, we could take action. We have taken action in those cases. We also would consult with the Health Rights Commission with which we have a close relationship. It is established in both of our acts that we must consult with each other about such matters. They may take it on as a health service complaint. We would also, if it was an aged care service, report that to the aged care standards area because we have a memorandum of understanding that we would work with them in that case. If, out of those investigations of the health service, there came concerns about individual nurses, we would address those concerns.

Senator WEST—So in Queensland you cannot take any action against a nurse unless you get an individual complaint. What happens in other states?

Ms Raven—We have the same process, the same system of regulation. Basically, nurse regulatory authorities around the country register nurses; they accredit nursing programs; they have a complaint system in place so anyone in the public can make a complaint about the practice or the health of a nurse; and they set practice standards within that jurisdiction.

CHAIR—Let us go to a tougher scenario: somebody has told you that—it is beyond doubt that this is a responsible not a mischievous complaint—nurses in course Y going to that place are being sold a pup. What do you do?

Ms Raven—If we can identify the nurses—

CHAIR—Did you not say that you look at the courses?

Ms Raven—I am sorry, I did not hear the last part of your question.

CHAIR—You said that, in answer to a question from Senator West or me, you deal with individual nurse situations. You also said, 'We accredit nurses and we also look at courses.' If, in the course of a course, you discover that an institution is hopeless, what action can you take?

Ms Raven—We might discover, in our accreditation area, that an institution is not meeting the standards from the monitoring body and we would ensure that students were not going there.

CHAIR—How would you do that?

Ms Raven—We would accredit the program and inform the university that the institution needed to be looked at, in terms of the quality processes that they had in place for facilitating quality placements for students in their program.

CHAIR—Can you black-ban the placement? Can you say, 'You can't send them there; they are hopeless'?

Ms Raven—If the university agreed to that, it would have an impact on their ability to run a course. That is a possible outcome.

Senator KNOWLES—Would you face possible litigation from that place for mentioning their name in an adverse circumstance?

Ms Raven—Yes, that is possible. We would have to look at how we did that. Usually, the universities want their graduates to be registered. For that to happen, they need approval by the Nurses Regulatory Authority for their course. They are the teeth in the process.

CHAIR—It is a bit hard to find where you put the bite on. You may have teeth, but when do you snap—if I can push a lousy pun?

Ms Raven—I cannot give you an example of that particular issue arising.

CHAIR—Have you brought action? Have you risen up in high dudgeon and said, 'Right, we are going to move in on them'?

Ms Raven—No.

Senator WEST—Have any of your affiliate bodies made recommendations to the state health department to say, 'That particular place'—institution or facility, or whatever—'is a problem'?

Ms Raven—As Dr Fox-Young referred to before, we would pass on to the Health Services Commission or—as it is called in Queensland—the Health Rights Commission any issues that relate to systems of health service delivery.

CHAIR—What if you get a complaint of the sort we are talking about in Queensland? Would you ring up Dr Fox-Young and say, 'Deal with that,' if she had not already heard about it? What if X institution was hopeless, and therefore the course that sent people there was in danger of losing its accreditation, and you had trouble ticking off on the nurses coming out of it because they were having a period of lousy education?

Dr Fox-Young—We would consult with the university on that. I believe that the university would have withdrawn their students before they got to that stage.

CHAIR—Say they have not.

Dr Fox-Young—Then we would tell the university that they needed to look very carefully at the kind of supervision they were giving students in that area.

CHAIR—I am a university; I am not frightened by that. What else are you going to tell me?

Dr Fox-Young—We can withdraw their accreditation.

CHAIR—Have you ever done that?

Dr Fox-Young—We have got as far as threatening. We have not actually withdrawn it.

CHAIR—Did they change?

Dr Fox-Young—Yes, and it was not over that particular kind of issue.

CHAIR—Can you give us any documentation that tells us who, what and why that was?

Dr Fox-Young—It is possible that I could give you that documentation. I would need to go back into the files. It was a few years ago. I would need to check our legal position on releasing that. It might be confidential.

CHAIR—Thank you. That was extremely useful for us. I have not really got time to ask the questions I would like to about complaints if a nurse were behaving badly. Presumably you are the people who would strike a nurse off?

Dr Fox-Young—Yes.

CHAIR—Can a nurse hold dual registration?

Ms Raven—Do you mean across borders?

CHAIR—Yes. I am enrolled in Queensland and New South Wales; therefore I can walk through Tweed Heads and work both sides of the border.

Dr Fox-Young—You can.

Ms Raven—The Australian Nursing Council has a policy that we have all agreed with about waiving fees when there is cross-border practice.

CHAIR—So if you are registered in Queensland you do not pay New South Wales, and vice versa?

Dr Fox-Young—Yes. We also have a policy of notifying our colleagues in other states if we suspend or limit anyone's registration.

CHAIR—One thing that you mentioned that I think is terribly important is IT. Almost nobody has raised it at all. I think it was in the ANCI submission. You talk about IT in recommendation 12, on page 17. If you are the people who accredit what it is necessary to know to be a good nurse, are you concerned now about computer literacy?

Mrs Gendek—I do not think that is a particular standard, but Dr Fox-Young might be able to elaborate on that, being the accreditor of courses.

Dr Fox-Young—It would certainly be one of the areas that we would look at. To function in today's society you need to be computer literate, and to function in some health care facilities these days you need to be more than computer literate; you need to be very familiar with them. It is not something that is specifically identified in our accreditation process or our standards. Our standards look more at adequate resourcing, adequate standards within the organisation, and the kinds of people who are employed to provide the educational process. We ask whether the organisations are appropriate and whether the course is likely to produce a graduate who is able to meet those standards.

CHAIR—Take this example: I have just graduated, I am an RN, I have just hit the wards, and I am looking for support. There are three nurses from the agencies who are better qualified, but they are part time. So they have put me in charge of the ward but I do not know how to turn a computer on. How am I going to feel at the end of the day?

Dr Fox-Young—I would be worried that you got through university these days without being able to turn a computer on.

CHAIR—I would be too, but do you know if that does happen?

Dr Fox-Young—Not that I have ever heard of, no.

CHAIR—I suppose we could go look for them.

Dr Fox-Young—We could. We have had new graduates reported to us as being not as good as they could be. I suspect part of that is that they are not being as well supported as they could be in organisations.

CHAIR—Are you aware that over the last few years the Commonwealth government provided, to any doctor who applied, $3,000 to assist with the purchase of computers?

Senator WEST—They are doctors, not nurses.

CHAIR—Stop it, Senator West; that is my next question. Are you aware of any such facilities being available to nurses?

Dr Fox-Young—Not to my knowledge, no.

CHAIR—I am a bit interested that you say you do not think anybody would come out of a nursing course without being able to turn on a computer. Nurses have told us that the demands on them to input information about each patient and so on mean that they need to be pretty skilled. Are you leaving it to the universities to tick that off as a competence? Why is that not in your area of responsibility?

Dr Fox-Young—One of the things that always concerns regulatory authorities, and, I imagine, universities as well, is what detail level you get down to in ticking off skills, tasks and ability to perform certain activities. The regulatory authority does not get down to that level. We get down to the level of whether they are able to demonstrate broad competencies in their ability to assess patients and to plan and provide care for them.

CHAIR—But by and large you do say that, if an accredited institution has ticked these people off as passing RN, that is good enough for you.

Dr Fox-Young—Yes, because we have accredited the organisation and approved their course.

CHAIR—Could I ask one last question: on page 6 you tell us some very interesting stuff about how many nurses are whizzing around the world. There is a wave of nurses going out of the UK and into America, out of America into somewhere else, and they are all moving around Australia—

Dr Fox-Young—They are indeed.

CHAIR—But you add a line that really has taken me back a little. It says:

Anecdotal evidence suggests that the majority of these are aged in their thirties and are seeking a one-year contract for career development.

On what evidence?

Dr Fox-Young—I am sorry, but I cannot find that.

CHAIR—Oh, I am sorry; this is the ANC's submission. I beg your pardon.

Mrs Gendek—I recognised what you were saying, Senator. The information that that came from was provided by a consultant who has been doing work in relation to the international movement of nurses and the recruitment of nurses. Did you specifically want some more detail about that?

CHAIR—We have been told different information. We have been told that there are lots of nurses who graduate and then—they may put their toe into the ward first—they are off. They are qualified as nurses, they are off to see the world, and they are taking their nursing training from Australia. They do not wait until they are 30, and they are not seeking a one-year contract for career development, although that sounds like the euphemism of the day, I would have to say.

Mrs Gendek—I met a colleague in the supermarket the other day who is in her 40s and is doing exactly that.

CHAIR—You can tell me later how it is improving her career. At this stage I would have to say thank you very much indeed. Your evidence has been extremely useful to us.

[2.32 p.m.]

CAHILL, Ms Anne Elizabeth, National Director, Women's Hospitals Australasia and Children's Hospitals Australasia

KINGSTON, Ms Jann, Convenor, Executives of Nursing, Children's Hospitals Australasia

OATS, Dr Jeremy J. Nicolle, Vice President, Women's Hospitals Australasia

GLENN, Ms Colleen, Executive Committee Member, Directors of Nursing Association Queensland (Inc.)

SUMMERS, Mrs Glynda, Vice President, Directors of Nursing Association

GOOLD, Mrs Sally Sophia, Chairperson, Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN)

CHAIR—Welcome. I would particularly like to thank the hospitals group, because you have assisted the committee by your preparedness to appear at today's hearing. The committee prefers all evidence to be given in public, but should you wish to give any evidence in camera you may ask to do so and the committee will give consideration to your request. I also need to remind you that evidence given to the committee is protected by parliamentary privilege and that any false or misleading evidence could constitute a contempt of the Senate. The committee has before it your submissions Nos 31, 936 and 837. Do you wish to make any alterations? I invite you now to make some opening comments and then field questions. Perhaps we will start with the Congress of Aboriginal and Torres Strait Islander Nurses.

Mrs Goold—CATSIN was formed in 1997 because it was recognised that there are so few Aboriginal and/or Torres Strait Islander registered nurses. As a matter of fact, we make up 0.5 per cent of the total registered nursing population in this country. When we started, as a result of the forum, we believed that there were issues that needed to be addressed. I think I sent a copy of CATSIN recommendations to you with my submission. If not, there is another one here for you. CATSIN is really concerned about the recruitment and retention of indigenous peoples into nursing. Recruitment does not always seem to be a problem; it is the retention that is a problem. That is what my submission is based around.

Ms Kingston—Thank you for the opportunity to appear before this inquiry today. The key issue for both the Children's Hospitals Australasia and the Women's Hospitals Australasia is that national leadership on nursing and midwifery issues is required. Hospitals are struggling to find qualified and appropriately skilled nurses and midwives. This cuts across state and territory jurisdictions and often sees hospitals competing against one another for scarce, talented resources within Australia or overseas. We would urge the inquiry to recommend a national approach to the policy issues surrounding the nursing and midwifery work force in the same way that there is already existing a national approach for the medical work force.

Another key concern is about ensuring an appropriately educated and flexible work force in rural and remote Australia. Again, a key issue is national leadership and support. There must also be recognition by all levels of government of the need for nurses and midwives to access continuing education to maintain and update their skills. This is essential for high-quality, safe, cost-effective care.

Dr Oats—Thank you also for the opportunity afforded the association today. Firstly, I wish to tender the apologies of Helen Gunn, convener of the Executives of Nursing and Midwifery of WHA.

A fourth key issue is not the perceived shortage of nurses or midwives but the fact that there are so many nurses and midwives who have left the field and do not wish to work in the industry. We are not sure how many there are because there are limited opportunities at a national level to accurately record this information.

We are concerned, too, that the current professional indemnity arrangements for midwives and also obstetricians will affect the capacity of the health industry to provide high-quality, safe, cost-effective care; consequently, a national approach to this issue is essential.

A sixth key issue is the interaction between the service delivery agencies, predominantly hospitals, and the education system, which affects the quality and experience of the nurses and midwives who are entering the work force. In addition, we wish to draw to senators' attention the issues raised in our submission under the heading 'Strategies to retain nurses in the work force', concerning the need for flexibility in work force practices and appropriate remuneration.

Mrs Summers—Thank you for the opportunity to participate in this inquiry. The Directors of Nursing Association consists of directors of nursing and assistant directors of nursing in both the public and private sectors—more recently those in the private sector are also able to be members. The predominant issue that the directors of nursing are concerned with relates to the coordination and monitoring of the labour force, both nationally and state wide. That is why there is a recommendation that a standing committee be established to monitor labour force issues across the country. Also of concern is the lack of incentives for nursing in relation to postgraduate education and the need for participation by the universities and the facilities in a joint advisory committee. Those are the key issues that surround the Directors of Nursing Association's submission.

Senator LEES—Mrs Goold, this morning we had a number of the universities before us and they raised the issue of retaining indigenous students. Each of them seemed to have an indigenous unit within their universities. From the perspective of indigenous nurses, what are some of the key issues that the universities need to deal with and what are some of the issues, particularly relating to retention of students from rural areas?

Mrs Goold—As far as support units within universities are concerned, most university campuses in this country have Aboriginal and Torres Strait Islander support units but they are not strictly relevant to nursing students. Unfortunately those that, with the best intentions, are offering support to student nurses do not have a nursing background, so there is a difficulty as far as the students are concerned.

As far as the retention of students is concerned, racism is alive and well in the tertiary sector and in the health care system.

Senator KNOWLES—Could you give us examples of that type of racism?

Mrs Goold—Certainly. There is certainly institutional racism as far as indigenous students and indigenous registered nurses are concerned. From my own experience, it would appear that indigenous people are only capable of caring for indigenous peoples. Yes, you may shake your head; I shake my head too.

Senator KNOWLES—Dreadful, isn't it?

Mrs Goold—It is. That is what is happening in the education system at this time as far as the education of indigenous peoples is concerned. It has been mooted that they would set up a separate program for indigenous people. It just seems to me that, again, near enough is good enough. As far as the health care system is concerned, generally when the students go out on the clinical pracitums there is racism out there. It can be nurse-to-nurse, nurse-to-student or patient-to-student racism. I guess you could also include in that the allied health professionals. I am not saying that this occurs with every person and in every instance and in every setting, but it is there.

The other issue of racism in university settings, in the schools of nursing, is that, because you are black, you are expected to know all there is to know about black issues. You are set up in class with the reference: 'Isn't that right?' I do not care who it is, you cannot ever hope to be an expert in all areas. As there is diversity in the wider community, so too there is diversity in Aboriginal and Torres Strait Islander areas. Can I go on?

CHAIR—Yes, please.

Mrs Goold—That leads me to another point, in that there is really a dearth of educational strategies in place within schools of nursing as far as indigenous issues are concerned. I have brought along for you a draft entitled *Indigenous health in core nursing curricula and the development of recruitment and retention strategies for indigenous Australians in nursing education*. This was done in partnership with the Australian Council of Deans of Nursing, the Office of Aboriginal and Torres Strait Islander Health Services and CATSIN. I do not know whether you have had access to this draft?

CHAIR—We would very much appreciate it, Mrs Goold. The committee secretary will collect it from you shortly.

Mrs Goold—I brought it along for you just in case you had not had access to it.

CHAIR—We appreciate that.

Mrs Goold—There are many issues that I have addressed in my submission that home in on that. Another difficulty is people leaving their communities.

Senator LEES—After the student graduates—presuming they have made it all the way through and over the hurdles—what sorts of support systems are needed then, particularly if a student is going to go remote? Some indigenous students may choose not to, but what support systems are needed for those who move out into communities?

Mrs Goold—CATSIN is trying to set up a mentorship program to mentor, certainly, the new graduates. I think there is very little mentoring for indigenous people—in fact, across the board—within health care settings, although new graduate programs are set up. Certainly, to cater for the indigenous person's needs, we would like to see more indigenous nurses employed to apply and implement those mentorships.

Senator LEES—And are you able to work with non-indigenous students who may choose to move to an indigenous community on cultural issues and on issues that may help them settle?

Mrs Goold—Yes. What I am hoping to do as far as CATSIN is concerned is to develop a program that can be then added to according to whichever community the person is going to work in. I do not believe that any new graduate should ever go or be sent to, or apply and be accepted to, work in remote Aboriginal communities until they have had cultural awareness and cultural safety programs implemented. What I would also like to see is academics as well as those in mainstream health care settings undergo those cultural awareness programs, too. Aboriginal people are not just in remote areas. We are everywhere.

Senator WEST—Should they be sending new graduates out to remote communities, either?

Mrs Goold—No. I do not believe so. I do not believe they should be because there is an awful culture shock, really, for them, and I do not believe they should be sent out.

Senator LEES—This question may also be relevant for the women's and the children's hospitals. Looking specifically at indigenous midwives, is that a specific area of critical shortage? Are we actually working on that area in terms of training and support?

Mrs Goold—There are a number of indigenous midwives out there, but we have come up through the ranks from the old-school setting. If I could just deviate for a moment: the Vertiel Philanthropic Association, of which I was a committee member, had given funding for CATSIN to provide bursaries for indigenous nurses to undertake postgraduate midwifery. As a result of that funding that we have been given, we have had five new graduates go through the system in the postgraduate area.

Ms Kingston—From the point of view of the Children's Hospitals Australasia, I am aware of processes that our member hospitals have implemented in an attempt to recruit indigenous nurses, but they have not been very successful. That is the only point I can make.

Dr Oats—From the WHA perspective, I am aware that at least one and probably more hospitals in Sydney specifically have had skills transfer programs, which have been supported by the RANZCOG as well, for upskilling people from remote areas. That has been an active program for some time.

Senator WEST—In relation to women's hospitals and children's hospitals, how much of a problem is the issue of getting adequate numbers of students to undertake the study of midwifery and the variation that seems to be taking place as to how they can undertake it?

Ms Cahill—Enormous. As you know, it happens in universities. The problem for us is more one of supervision and then retaining the students as we get to employ them. But as we have said in our submission, the range of courses available is of considerable concern. I know Professor Oats was going to mention that. We have discovered in our participation in the research project that there are some midwifery courses that last for six months that you could do by correspondence and there are some that last 1½ years. Our directors of nursing and midwifery across Australasia very carefully scrutinise the curriculum vitae of candidates for jobs to actually see where they have been, and decide on that basis whether or not they will take them on. So there is a range of educational outcomes that we may or may not want to use in our hospitals.

Senator WEST—Do we need to go back to the old days of actually having a midwifery certificate? My way was: do general, then go and do mid. Do we need to go back to that?

Dr Oats—There are two issues with that. Most now come through a master of midwifery. It is a postgraduate qualification with a variation in experience, I think on behalf of member hospitals, where they work locally with the training institutions to provide the practical experience. This obviously varies enormously from centre to centre, as Ms Cahill has just mentioned.

Ms Cahill—I guess, in the 'good old days', as they may have been—

Senator WEST—Or may not have been.

Ms Cahill—we were funded to supervise students. The supervision is a key component, so our hospitals tell us. You are expected to deliver babies, look after the ladies postnatally and antenatally, and teach someone as well, for heaven's sake.

Senator WEST—What has happened to the staffing ratios from back in, say, the early seventies or whenever it was?

Dr Oats—There has been a radical change. The number of patients, for example, that each midwife has to look after has radically changed. We are looking at fewer and fewer midwives for more and more patients. The other major issue is that, with the shorter length of stay of the women, the time demands on midwives of looking after not just their care but also education, particularly after delivery where they have to get an enormous amount of information over, have put them under very large pressure. I think that is one of the factors that is making midwifery less attractive.

The acuity of problems that women now come with—medical problems, for example, in pregnancy—has increased. There are conditions that 10 years ago we would not even expect a person to survive through to reproductive age. You see it very much in delivery suites, for example. For a certain group it is an intensive care type situation where we need very highly

skilled midwives. Again this puts enormous pressure on them. So that turnover and throughput of patients is a very major issue.

Senator WEST—Is there any set ratio for number of midwives per normal delivery?

Ms Cahill—No. Maybe there are some informal rules that work from hospital to hospital and from state to state. As you may be aware, the Australian Health Workforce Advisory Committee is looking at this very issue. Numbers that have been suggested are one midwife to about 40 deliveries. That was just a number plucked out of the sky that we discussed the other day at one of our meetings.

Senator WEST—This is normal postnatal deliveries?

Ms Cahill—We made that point that you actually could not do it. For example, in our association we have 31 member hospitals that range from the Royal Women's Hospital in Melbourne, a highly complex organisation. Even Townsville is a very complex organisation as well due to the mix of patients.

CHAIR—Over what time?

Ms Cahill—You work it out over a year.

Senator WEST—One RN to—

Ms Cahill—To 40 deliveries a year. This number has been discussed informally amongst different groups. We would say that number is probably not enough for the organisations that we see. It would be closer to one to 20, maybe lower.

Senator WEST—I guess I am thinking that back in the old days a 40-bed ward would have, on the day shift, two or three registered midwives, a couple more in the nursery plus half a dozen pupil midwives. What sort of staff numbers do you have now?

Ms Cahill—Firstly, we hope we have not got any 40-bed wards.

Senator WEST—Well, maybe a 20-bed ward.

Dr Oats—It does vary very much from institution to institution. It also varies between the public and private sectors as well. In delivery suite, for example, I think most delivery suites would work on one qualified midwife per two labouring women. The nurseries now have been closed in most institutions, so the midwives on the floor are also looking after neonates, young babies, as well.

Ms Cahill—We could do a quick and dirty data analysis for you.

Senator WEST—I would be interested.

Ms Cahill—It is not a question I have thought about a lot, because we are so busy trying to impart the information we have over 2.54 days or whatever it is for a normal vaginal delivery.

Senator WEST—Yes. Then, given that lactation does not even think about occurring until about day 3 or day 4, what community supports are there available for the patients and what training are the midwives being given in how to actually be community midwives? There is a hell of a difference between being a midwife and a lactation consultant in a hospital and doing it at home.

Dr Oats—From our perspective, we can really only comment on the in-hospital phase. Many institutions now have an outreach service which will variously look after women for five to seven days, once they go home. Again, some may have a visit every day and some may have visits on alternate days, depending on needs. Once they leave that, it is into the community. We are certainly aware of the reduction in the number of community nurses and facilities in some states, so for us that is a major concern, although it is not directly under our influence.

Ms Cahill—It highlights the different funding mechanisms and their impact on the health system. For example, the hospitals—I hope I am not telling you how to suck eggs—are state funded and the community midwifery program is a local council responsibility, and never the twain shall meet.

Senator WEST—What about children's hospitals? You represent children's hospitals as well, so I assume this is about paediatric trained nurses rather than mothercraft or neonatal intensive care trained nurses.

Ms Kingston—The majority of them are general trained and then they do postgraduate training in paediatrics.

Senator WEST—What is happening in the area of what used to be mothercraft? Who is running the normal, well baby clinics? Where do the early childhood nurses pick up their training?

Ms Kingston—There are still early childhood nurses and early childhood services, and Tresillian still undertakes courses.

Senator KNOWLES—I would like to ask the directors of nursing about horizontal violence. What are the directors doing to prevent such practices? I expand upon that—having listened to and read Ms Goold's submission—to ask what they are doing about evidence of racism.

Mrs Summers—There are mechanisms, strategies and support services available for directors of nursing and other staff in relation to horizontal violence once it is identified. This is a little difficult, because we have not discussed this as a directors of nursing group per the submission.

Senator KNOWLES—We had not thought of it before this inquiry either.

Mrs Summers—I am concerned as to whether I am representing the group per se with my comments.

Senator KNOWLES—I could probably get you off any hook that you might end up attached to in a responsible way with regard to your members. Surely, in your case, some of the dons would be perpetrators of such violence. If they are not, they should be in a position to witness such violence or bullying going on. Therefore, I would have thought there would be management practices within the system to deal with it. If they are the perpetrator it is obviously a different set of circumstances but, if they are a witness, surely they would be able to act swiftly to make changes where necessary.

Mrs Summers—Speaking personally, that is something that happens in practice—certainly when they are made aware of it. There are support mechanisms within the government sector to tap into resources for counselling and for communication experts to discuss with the staff to identify the key issues and work with the group or individual to resolve some of those issues. So there are certainly some mechanisms available that are utilised.

Ms Glenn—I also emphasise—only from the Queensland Health perspective—that cultural awareness training is an expectation. Operationalising that down to every single staff member participating in that is certainly a challenge and not necessarily able to be met, but that would be another way of addressing this through an education process.

Senator KNOWLES—Are you aware of any litigation that has happened as a consequence of such bullying, given that harassment in the workplace is generally recognised as illegal? We have not yet, to the best of my knowledge, had any evidence that anyone has actually sued for such practices. Do you know of any instances where this has happened?

Mrs Summers—I am not aware of any individual instances.

CHAIR—Ms Kingston indicated she might say something.

Ms Kingston—I have had the experience, and I have knowledge of circumstances where claims of harassment have been dealt with through a WorkCover strategy. Certainly there are instances where people have pursued it, not to the level of legal action, but certainly through the WorkCover processes available in each state.

Ms Cahill—It is worth adding, as well, that a number of our hospitals have been quite conscious about bullying generally. I thought that we were not being racist in the health care system, and I am about to go back and find out whether we are or not. We are running sessions at some of our meetings to talk about how different hospitals are handling the issue of bullying, because it is across the hospital sector and not just in the nursing division, the allied health division or the medical division.

Senator KNOWLES—While it is a very localised problem and we are not, as you have identified, responsible for funding nurses, it nonetheless impacts on the retention rates. That is where I want to come to you, Mrs Goold, because you have said in your submission that retention rates are potentially a problem for ATSI nurses. What is different about the ATSI nurse retention rate, as opposed to anybody else?

Mrs Goold—Which issue are we discussing—just the broad retention issue?

Senator KNOWLES—Yes.

Mrs Goold—You may or may not be aware of how many indigenous people complete grade 12. It is a very low number. Certainly some people who come in and undertake the undergraduate nursing program are from school—I cannot say that there are many. Many are mature age entry students, and they do not have the science background that is required. Many have literacy and numeracy skills that are not as advanced as they ought to be and so they are behind the eight ball right from the start. Even though the support may be there for them, it is extremely difficult—

Senator KNOWLES—So how do they get in in the first place?

Mrs Goold—From the mature entry perspective—the mature entry requirement. I know from when I was teaching at QUT, the mature age and special entry people do an entry test or exam, but it is fairly basic. Unless the support structures are there, we are continuing to set people up to fail.

Senator KNOWLES—So do I conclude from what you say that the drop-out rate is more related to the mature age students than to the younger ones coming straight from school? Surely the scores of those coming straight from school would have to be equivalent to those of anybody else who was coming straight from school?

Mrs Goold—Yes. We have found the mature age people have major difficulties, plus when they come into programs they are probably the sole breadwinner in their family and have two or three—or more—children. If they are away from home and from support systems, it makes it extremely difficult for them. They need a great deal of support.

Senator KNOWLES—I will just come back to what you were saying earlier about the identification and eradication of racism. You list the institutional settings—the schools of nursing and the hospital settings, even when students are on clinical placements. I think we would be whistling Dixie in the west wind if we thought racism was ever going to die completely—

Mrs Goold—We live in hope.

Senator KNOWLES—We do live in hope, exactly. But I am keen to know what you think should be done about eradicating racism?

Mrs Goold—I believe, as I said earlier, those teaching nursing need to undergo cultural awareness programs. I also believe that curriculums in schools of nursing need to be revised to ensure that there are stand-alone subjects on indigenous issues and indigenous history so that people will understand that so many of the health problems are a result of the historical factors. I do not believe that you can go in and just say, 'Well, this is all very nice and we should be doing'—this, that and whatever else. Unless people have a thorough grounding in the historical factors for nursing, unless the students learn this, to give them a better understanding when they are caring for indigenous people out there in the settings—

Senator KNOWLES—By that do you mean explaining to them why the level of diabetes is so high—all of those sorts of things?

Mrs Goold—Sure—certainly the historical background of separation from land, separation from country, not being able to practise their ceremonies and speak their language, and the major psychological impact that this has had on indigenous people. I also think that most student nurses come from white, middle-class backgrounds and, in many instances, have never had anything to do with an Aboriginal person. How are they to understand and provide care for an indigenous people from a different culture, with different needs?

Senator LEES—The way I see it, I think there is also an in-built problem with the bureaucracy that runs a whole lot of these things. I am from Western Australia. A few years ago I had an ongoing battle with accreditation for a nursing home in the Kimberley region of Western Australia. They were threatening to whip its licence away from it because people were living out on the verandahs and a lot of the old ladies were not prepared to wear incontinence pads and things like that. One cannot believe, in this day and age, that the bureaucracy could be so ill-informed as to say they must all be in a bed and they must all be wearing knickers and incontinence pads and things like that. It is such a blast from the past. That is why I ask you: is there some way in which we, at a federal level, can have an impact on bringing people into 2002 and beyond?

Mrs Goold—If you have impact, I would do anything to work with you to overcome these problems—anything. Perhaps these cultural issues will rub off by osmosis if we can teach people to see that Aboriginal people are not invisible, that they are people with needs. We need to get student nurses to see that we are no different: we bleed the same, we get upset about the same things, we weep about the same things; probably we weep a little more about other areas.

Senator LEES—Could I just move that question over to the women's and children's hospitals. When I have visited, unfortunately I have seen in your neonatal wards a disproportionate number of indigenous babies. What sort of cultural programs, cultural training, is there for the nurses who are in particular dealing in wards here in Queensland where there are quite a number of indigenous babies?

Dr Oats—I have actually left Queensland, so I have some difficulty speaking on its behalf. Certainly, when I was at the Mater here there was an Aboriginal liaison officer and there were a number of courses run on awareness. I cannot give you details of the depth that went to.

Senator LEES—Perhaps you could take the question on notice. I am only too happy for you to go back to the women's and children's hospitals and bring to the committee any strategic plans they have. This brings me to another question that Mrs Goold has raised, regarding qualifications of students getting in—and this draws me to your submission from the hospitals, recommendation No. 5, that:

… consistent national standards be applied across secondary schools—

and departments. I know this happens in some states where there are no requirements for a student to have done any maths and there are no requirements for a student to have done any biology or any of the sciences. They can in fact get into university and, as valuable as arts and

music are, they do not quite prepare people for nursing. Is this the road that you are heading down in your recommendation 5?

Ms Cahill—Recommendation 5 was more about getting kids to come on work experience opportunities within our hospitals. They are the ones who may come back once you have given them a good experience. We are finding across Australasia that there are requirements to get them in for work experience. In New South Wales for example, in all except one hospital, the requirements are just overwhelming and people do not bother with it. So it was more about that.

Ms Kingston—It was about making sure that people who were interested in looking at nursing as a career had access to work experience whilst they were still in secondary school.

Senator LEES—And this is not the case at the moment generally.

Ms Cahill—No. Even within states, it is not the same—there are not the same opportunities.

Ms Kingston—Some of my experiences recently—particularly in New South Wales where I speak from my own experience—in terms of the requirement to do a working with children check and the extra bureaucratic processes associated with having those school students come into the organisations, interest from both the high school and the organisation, the health care facility, is declining in running those programs or participating in those programs.

Senator KNOWLES—Let me finish up on this particular issue that relates to this document, Mrs Goold, that you gave us today on the report on the key themes arising from the indigenous nursing education workshop. The deans of universities were present. What sort of reaction have you had from deans in getting their awareness to filter through with all the issues that you have raised?

Mrs Goold—We have had a very good response from the deans of nursing. They have accepted our recommendations from the blue book that you have there. As far as the workshop is concerned, the response to that has been really good in actual fact. I have had several people contact me to say that they are now wanting to review their curriculum and to ask whether I can assist them with this. I would be only too delighted to assist them with this. I think at least there is movement.

As you said, we have a long way to go. I felt quite heartened when I got those responses. I thought perhaps that I would see change in my lifetime and that Aboriginal people would be able to receive the health care that they deserve. People have to be made more culturally aware. You were talking about the little children in hospital, and we all know that little black kids have a high hospitalisation rate. It is about having mum there and being able to have the extended families and for those people to be able to come without people being judgmental of who they are, what they look like and how they behave.

As you would be aware—you do not need me to tell you—health care settings do not always welcome indigenous people, unfortunately. As I said earlier, we have nurses and those other people, the allied health people, doctors and others looking and seeing Aboriginal people and listening to them. They know what their problems are and I think we need to do them the service to listen to them.

Senator McLUCAS—We have had evidence this morning from a number of other organisations when we have asked them how to encourage more indigenous people into nursing and have them stay in nursing. Basically, scholarships are the strategy that they generally adopt. First of all, do you concur with that? I suppose we can ask the panel that.

Mrs Goold—I certainly do, to assist them.

Senator McLUCAS—I suppose the other part of that question is: what else can we look at?

Mrs Goold—Nursing has been notorious in not selling itself to the public, not just to indigenous people but to the public. I am sure the nurses sitting at this table would agree that we have been very bad at this. We expect people to come to us rather than us go to them. I think if we are wanting to look at getting indigenous people into nursing we have to start in primary school. If we leave it to secondary school, because of the low numbers that go through secondary school, we have lost them. We need to get out. I did put in a submission asking for project officers in each state, indigenous nurses, to go out and speak to the school students. Most of CATSIN members go and speak to schoolkids when they have the opportunity. When I go to communities, I speak to the young ones. I think if we do not get them then we have lost them. We should offer nursing and I certainly agree with the strategy for them to go in and experience it, to see what happens. I know that there are difficulties in that as far as bureaucracies are concerned. But it would be good for them to go in to have just a little bit of an experience. I say to the kids, 'Look, you can do whatever you want and be whatever you want to be if you really want to do it.' I went into a school—I will just tell you this as a little aside—and I asked these little kids what they wanted to do. One wanted to be a bouncer. I thought, 'God love you, darling, if that is the highest that you can really aspire to,' and I felt a great sadness. We need to set their sights just a little bit higher.

Ms Cahill—One of our key recommendations is that we want scholarships provided as a routine for indigenous people for nursing and midwifery places and that is the discussion around recommendation 7 in our submission.

Senator McLUCAS—Thank you.

Mrs Goold—If I could just butt in—I am sorry to be hogging the floor here. You may be aware of the CURRNS scholarships, which are Commonwealth Undergraduate Rural and Remote Nursing Scholarships. On the first round of those, 17 indigenous students were successful, which was really good. Initially they had 100 scholarships and 10 for indigenous students. I said, 'Why only 10?' Seven won it on a level playing field by competing and I said, 'What about the other 10?' so they are there. Also there are the Puggy Hunter scholarships now. We have selected two nursing and two medical ones for this year.

Senator McLUCAS—Does CATSIN or any of the other members of the panel have any views on whether or not it is possible to use a system of distance delivery of nurse undergraduate education, where nurses would be trained—and I know this sounds like a reversion to what we used to do—in their town of origin? We are doing this with teacher education and with child-care education in Queensland. Have we thought about it in nursing and is there a way of supporting those people coming from rural places to be trained at their home?

Ms Cahill—We have. We found, as I mentioned recently, a six-month midwifery course, which was a direct entry course. I am going to do it by distance education so that I can actually deliver babies, not figuring how to actually deliver a baby in the end. The key component obviously is the clinical placement. In clinical work the maxim of seeing one, doing one and then teaching one actually works really well, doesn't it, to a point? You can read about delivering a baby or putting an IV line in a child and so forth, but you actually need to do it. I might be corrected here because I am not a clinician.

Senator McLUCAS—I am talking more about undergraduate training and the full training so that you do not have to attend a university in Cairns, Townsville, Toowoomba or Brisbane.

CHAIR—Dr Oats?

Dr Oats—I can certainly see a place for it. I think the dilemma is in the practical aspects of it. There are a lot of very good developments in models et cetera so that students can be trained on very realistic models with advanced telemedicine techniques, but I think in the end there is no substitute for the time spent with sick people. I think probably you need a balance with that.

Senator McLUCAS—Sorry. I am not expressing myself properly. In the teacher education model, students actually present at schools in isolated places. They do their education via the teachers at that school. They are usually employed as an assistant teacher in some way at that school, but they are also doing their university education by correspondence or digitally. The difficulty for nursing education, to conceptualise it, is the fact that that is what you used to do: you used to basically train at the hospital. You could not do it at the Kowanyama hospital, of course, but you might be able to do it at TI, and you might be able to do it at Mount Isa.

Ms Kingston—Perhaps I could comment. Certainly the clinical component is a significant part of the undergraduate nursing training, intertwined with the theoretical component. I am not saying that that model is impossible, but another issue of concern would be the ability to provide those students with clinical practice—well-supervised, valuable clinical practice.

Senator McLUCAS—Even at a hospital the size of TI, you could not do that.

CHAIR—Which stands for?

Senator McLUCAS—Thursday Island; I am sorry.

CHAIR—I just thought for the record we should all know that we were not talking about Townsville. Can I just follow Senator McLucas there? No matter what you think, you have been asked to do it. Can you do it? Can you actually gather up a busload of remote and rural students and get them some suitable clinical practice via an intensive course. Do you want it for four weeks or longer? What are you bidding for, Senator McLucas—an eight-week course?

Senator McLUCAS—I am bidding for a three-year course but not delivered at a university. I am not actually bidding, because I do not come from this profession, but I am asking us to consider it.

CHAIR—I am just interested to follow that. Could you actually gather up the rural and remote students and bring them for intensive clinical experience in chunks of four weeks or eight weeks or so each year?

Ms Cahill—There is no problem that cannot be solved by throwing money at it. I am sure that is possible.

Dr Oats—There are no such courses that I am aware of in nursing; but in other allied health and supporting areas they are already happening. There are a number of programs in Queensland that I am aware of that are doing this and giving an intensive one to two months of experience in women's health issues; so, yes, to the level to which you can go, I guess it would need further development.

Ms Kingston—I was going to comment that I am a nurse and it would not be impossible to get more nurses, but there would be a challenge in that model to actually link what they had learned in theory to what they were going to learn at the end of their bus trip. So, in terms of linking the theoretical component to what they were going to have in that four weeks of clinical experience, the development of the course would need to be carefully considered.

Mrs Goold—Perhaps I could make a comment. As far as that was concerned, there was a pilot program between Deakin University and Mount Isa. This program was set up a little while ago, and the students graduated two years ago from this program. There, the students had their facilitator and coordinator in Mount Isa and they went down to the Geelong campus of Deakin University. I do not know how many campuses there are at Deakin. But there were very major difficulties with that program: firstly, they were going from Mount Isa down to Geelong—and think of the weather there in the winter; secondly, these students were also subjected to major difficulties down there with the theoretical component and their clinical prac in the university setting. What had happened was that a doctor had wanted to keep the girls at Mount Isa.

Senator WEST—Trained the way he wanted them trained.

Mrs Goold—Absolutely. There are difficulties, but that program has ceased now. As I said, it was a pilot program. There is a program at this time being mooted by a doctor, with little consultation with the head of school of nursing at that particular university, wanting to run this program on Thursday Island. He believes that the students would not have to leave Thursday Island but would be able to get all their clinical practice there—which I think is an absolute nonsense. I go back to my statement earlier: near enough is good enough. I think this is an absolute scandal also—not just for the fact that this doctor is now poking his nose into nurses' business, but also because he thinks he knows what is best for nurses with this program, so that these people would not have to come off Thursday Island—never mind the fact that they still have to meet the ANCI competencies to register.

CHAIR—Mrs Goold, I am playing devil's advocate a little bit here. In terms of racism, you said before there is a suggestion that some people think Aboriginal people are only able to take nursing care of Aboriginal people, for example. What do you think of something like Alukara birthing centre in the Territory, if you know about it—

Mrs Goold—I do.

CHAIR—I thought you might—which essentially, I think, is women for women and Aboriginal for Aboriginal?

Mrs Goold—That is right. Congress Alukara is 'birthing by the grandmothers law'. They set this up and, because they could have traditional birthing practices there, it was really wonderful. However, the major problem has been socialisation in the wider culture. Under normal circumstances, young women have their husbands with them. Perhaps others here would be aware of Congress Alukara. With traditional birthing practices, men are forbidden to be present, but the young women want their husbands there as a source of support, and that is not allowed. So there is the collision between the two cultures as a result of the socialisation process. It has created major difficulties. But this was a wonderful concept.

CHAIR—Is it being modified in some way to come to terms with the needs of young Aboriginal people?

Mrs Goold—I think they are trying to work their way around it. It was really wonderful when it first started, because they had the backup support system as well.

CHAIR—People tell me that sometimes there is a sense of reverse racism: Aboriginal people will look after Aboriginal people in a traditional way and then suddenly find that they are not in the mainstream. I think this was more for Pitjantjatjara schools, for example, where children learned to speak Pitjantjatjara but then, when they got to secondary school, could not really speak English—and there have been some changes made. Can you comment on that?

Mrs Goold—Yes. As far as Aboriginal people caring for Aboriginal people—

CHAIR—And, therefore, perhaps disadvantaging them by that very process?

Mrs Goold—Certainly racism just does not belong to a white society; it belongs all over—and we can all practise that. What is happening now in the breaking down of these problems is that people are recognising that traditional healers have something to offer. That has been a major breakthrough: rather than having them on the outer, they are being included; there is inclusion of them as far as health care is concerned, particularly under 'remote areas'.

CHAIR—With backup support for Aboriginal care, I understand that the University of Newcastle has graduated a number of Aboriginal doctors, I think eight, about 12 months or so ago.

Mrs Goold—Yes.

CHAIR—My understanding is that it took pains to make sure that these young students were supported. Some people have said to me, 'Oh, they've just graduated them any old how.' My understanding is that the University of Newcastle would lose its total reputation if it graduated people who were less than competent. Have you talked to it about what steps it has had to take on behalf of these doctors?

Mrs Goold—Yes. CATSIN has a really good relationship with AIDA, the Australian Indigenous Doctors Association, and it is a nonsense to say that their education was any 'less

than'. But it had a very good support system in place, and these people are functioning out there extremely well.

CHAIR—What did that include? For instance, if you were Kevin Sheedy and you were trying to look after Aboriginal footballers, one of the things you would have discovered is that a lot of Aboriginal people like living close to other Aboriginal people.

Mrs Goold—Sure.

CHAIR—And they have sought out accommodation that encouraged that sense of community. It did not mean that they were isolated from anyone else. That is one example. Is that something that you would be looking for, for Aboriginal nurses?

Mrs Goold—Yes, of course—and to have a support system there: as you will see in our submission and also in that blue paper, to have Aboriginal registered nurses employed to provide the support, whether they are split between two or three schools of nursing and universities. Doesn't everyone relate better to their own?

CHAIR—There are some stunning exceptions to that claim, Mrs Goold, but we will not press it. Can I ask the Directors of Nursing Association: do you have any examples or evidence you can give us about what your organisation does to address these questions? For example, has your organisation looked at the insufficiencies—or not—of support for Aboriginal students, let alone any other students, who are struggling on the ward?

Mrs Summers—We do not have any Aboriginal nurses per se. However, we do have an indigenous liaison officer who is available for any of the students or patients that come through to our organisation, and also a cultural awareness program which is mandatory for all categories of staff. I think, Sally, you can take heart in relation to the benefits that I believe this program is having. When you talk to the staff who have attended these programs, there certainly is a change in their understanding and perceptions in terms of how they understand and acknowledge the indigenous culture. It means they are then able to better care for indigenous people when they come into hospital.

CHAIR—What do you mean by: 'We don't have any nurses in our organisation'? Did you say that?

Mrs Summers—No. We do not have any indigenous nurses or students that I am aware of that have come recently.

CHAIR—I was just interested if the Directors of Nursing Association would be looking at the responsibilities of directors of nursing who sometimes might have Aboriginal students in their care.

Mrs Summers—They will participate in a program. I will ask Ms Glenn: do you have a specific program at Ipswich?

Ms Glenn—Not for nurses. We just have the generic cultural awareness program and we work with the local Aboriginal and Torres Strait Islander Health Service. There is a lot of local

liaison there. The relationships that have built up and the absorption by osmosis of cultural issues has certainly been seen locally. I can only say that from my own organisation.

CHAIR—You recommend a permanent subcommittee of the Australian Health Ministers Advisory Council. Why?

Mrs Summers—Predominantly because there does not seem to be a national group that oversees the nursing work force and because the issues that surround the nursing work force seem to come in a cyclical pattern—with a shortage, then a glut and then a shortage. Perhaps if there was an advisory body, a steering group, that was actually overseeing this right across the country, we would be more in front rather than reacting to the situation, which we tend to be.

CHAIR—I am just wondering why you chose the Health Ministers Advisory Council as opposed to, say, a national nursing adviser and a national nursing adviser work force?

Mrs Summers—I suspect because of, perhaps, the standing that that would have in terms of being a subcommittee.

CHAIR—I am not sure I should say it on the record, but I will see you later, Mrs Summers, and tell you about ministerial advisory councils.

Mrs Summers—I am sorry.

CHAIR—My understanding is—and this is certainly a personal view—that if you really want a graveyard for any advancement, put it in the Commonwealth-state ministers advisory committees where it has nobody driving it, no direction et cetera.

Mrs Summers—I would take your advice.

CHAIR—I strongly suggest that you rethink that one. Of course, I will probably be hit behind the ear by somebody on the way out because of that. It is certainly my concern: if you really want to advance things you need to put it where there is going to be somebody whose job it is to advance it.

If I could look at this notion of an Australian nursing and midwifery registration body to be established under the aegis of the federal Department of Health and Ageing: do you want it to be separate from state bodies?

Ms Cahill—We do. It is the same principle. I do not necessarily care where it sits as long as there is a national and influential approach to managing the nursing and midwifery work force that is giving some leadership to nursing and midwifery policy in this country. We do not care where it ends up as long as there is some central approach.

CHAIR—I am interested in you saying that. You seem to suggest in your earlier contribution that there is a competition for midwives, that they are in such shortage that people are competing to get hold of them. Do you think that competition might be minimised if you went this way?

Ms Cahill—No, not necessarily.

Ms Kingston—I think there is a competition for nurses and it is very real for midwives as well. Our belief is that if we had a national approach then perhaps we would not end up in the position we are in now in terms of the numbers in the undergraduate work force—that a national approach to managing those numbers and the maintenance of undergraduate places would improve the situation.

Ms Cahill—We are competing not just with hospitals within Australia. We have made the point in our submission that it is actually quite instructive to sit at Changi airport and watch Australian directors of nursing go overseas and the English ones come out here. You could actually probably do the deal at Changi airport, quite frankly—do a bit of give and take. So we are not just competing amongst ourselves; there is a whole world out there.

CHAIR—That is certainly something that has become very clear in the course of this inquiry. Senator Lees read the front of the Adelaide *Advertiser* today. It actually was saying that one of the big challenges to midwives, as I understand it, is that they will not be covered by indemnity or insurance.

Senator LEES—This is actual students who need to get out and get their clinical practice and the insurance company has now pulled out. While the nurses in hospitals are covered, the students have no cover.

Ms Cahill—But the nurses are not covered in some states. For example, in New South Wales if you are an independent midwife and you have a relationship with a hospital you are not covered, as well. Let us be clear about that.

Dr Oats—I was hearing over the weekend that the same is applying to medical students in South Australia also, so they cannot be involved in deliveries. It is a very significant issue.

CHAIR—Can you please explain it a bit more for me and the committee: these are students in the Women's and Children's Hospital?

Dr Oats—I am afraid this is hearsay. I heard from a South Australian colleague at the weekend that insurance has been removed, so that medical students—and I assume it applies to midwifery students as well—are not indemnified if a problem arises with the delivery.

Ms Cahill—So it will not just be to the Women's and Children's Hospital in Adelaide—it is from the university to any of the placement hospitals around the state of South Australia. So it could be Flinders, it could be any—

CHAIR—As we are holding hearings in Adelaide tomorrow it is certainly something we will take with up them there. What would your suggestion to have a national nursing and midwifery registration board do to the rest of registration? Have you spoken to the state and national registration bodies about this?

Ms Cahill—We have, via a circuitous route. As you are aware, we are part of the Australian Midwifery Action Project and we know the requirements of the state and territory bodies and so

forth. If I may be so bold, we are not quite comfortable that we have got a good handle on how many they have actually got on their books, how many we need, what the national picture is and how many we should be training. There are different ways of registering, not just through the Australian Nursing Council. A person can register in South Australia and we won't know about them nationally or when they want to move or—

Dr Oats—There is one other issue too. We are aware of people who have not qualified. Their qualifications, for example, may be enough to get them registered in one state but they do not meet the qualifications if they had done it in another state, and they can get registered because of their previous registration. This difference in training and registration requirements is a concern.

CHAIR—That is extremely important. That is one piece of evidence that we have not really had given to us substantially in this inquiry. It has been a matter of: 'It is pretty comparable across the country.' Can you give us an example of which state is worse or better?

Ms Cahill—Not without going to jail, I think.

CHAIR—Yes, you can. You are covered by privilege. This is going to be ridiculous! If you want to you can provide it to us off the record.

Senator WEST—For instance, where is the six-month course?

Ms Cahill—We will find that out for you.

Senator WEST—And does that six-month course include any deliveries?

Dr Oats—The anecdotal information we were given was that it does not, but we can get details.

Senator WEST—So if a person got registered in that state for that course, and they then went to another state where they were expected to have 20 deliveries, witness 100 births, and do X number of babies in neonatal intensive care, they would automatically get registered because of reciprocity around the states. Is that right?

Ms Cahill—That is right.

Senator WEST—That is scary.

Ms Cahill—Yes.

CHAIR—Do you know of that in only one situation?

Ms Cahill—Only one has been brought to our attention.

CHAIR—Apart from this six-month virtual reality education, do you know of any other areas—in obstetrics, midwifery, paediatrics, neonatal, intensive care—where this is a concern?

Ms Kingston—I know that there is a variety in the course curriculum, but I do not have any evidence—

CHAIR—But on the whole you are comforted that if somebody has, apart from this course, qualified as a midwife in Perth, Adelaide, Hobart or Sydney, it is pretty comparable across the country?

Ms Cahill—From a women's hospital perspective but it is not what our directors of nursing and midwifery are saying. They are actually scrutinising where their candidates come from before they take them on, to make sure that they have had the right number of practical hours and so forth. It might be something that we will double-check on for you.

CHAIR—Could you, please. If you want to make it confidential information, we will cope with that. I think you should feel comforted to know that if it is in the public record it is in the public record—

Senator WEST—It does attract parliamentary privilege, so you cannot be sued for defamation.

CHAIR—What we could do is to ask if you can provide information. If you want to send it to the committee and change its status or say, 'Could you be cautious about this', then we can examine it and see whether we want to approach you about changing your request. I think that is terribly important, because, apart from the six-month course, you are saying that there are other directors of nursing who say, 'I'll take a nurse from X state—or institution—

Ms Cahill—Institution.

CHAIR—Okay. Are you talking about universities or hospitals?

Ms Cahill—Universities.

CHAIR—It gets even more exciting.

Ms Kingston—It is the same in the undergraduate programs. It is usually based on the level of clinical practice experience a student gets within that undergraduate program, but certainly there are differences.

Senator WEST—That was always the case, though. The practical experience you got depended on what wards you got rostered to in your three or four years. There was always a variation. You might have been unfortunate enough to have spent the whole time mostly in medical wards or surgical wards and never got to neuro or ENT or something.

Ms Cahill—Unfortunately, now it is a bigger issue, because we are trying to do more with less. We do not have that flexibility that we had in the good old days.

Senator WEST—They weren't good.

CHAIR—We have to finish, but I have asked a number of people about the brand name 'experience in times past'. If you were an RPA nurse, a Mater nurse, a St Vinnie's nurse or whatever, you got a tick. People just knew that they regularly churned out nurses who were up to scratch—so often that it was a tick in your favour. Is that beginning to happen already? From what you are saying, it sounds as though it is. If you are from university X: tick; if you are from university Y: questionable.

Ms Cahill—That is correct.

CHAIR—We would be very appreciative if you could provide us with some evidence about the institutions and courses that are causing some people some concern. Unfortunately, we have to finish there. Thank you very much for your participation and for going out of your way to meet the committee's needs.

Senator WEST—Could I just ask: what is a non-silo approach?

Ms Cahill—Across the whole of the health setting—

Senator WEST—You mean holistic?

Ms Cahill—No, it is not just holistic. We say that we are pretty good in the way we treat our women and children, because we consider them in our social setting, in their family setting. But a silo approach in relation to work force means that we are not going to just count the nurses and say, 'We can fix that by doing X, Y and Z'—as happened recently in dealing with paediatricians, for example. There was an issue in relation to the number of paediatricians we have in this country, so it was decided that we would use more paediatric nurses. Where are they? We do not have them, but someone decided this about paediatricians and did not think to involve the paediatric nurses in that discussion.

CHAIR—Thank you for your evidence.

[3.53 p.m.]

ATTENBOROUGH, Ms Vicki, Clinical Nurse Consultant, Child Youth and Family Health

MARRIOTT, Ms Jan, Clinical Nurse Consultant, Child Youth and Family Health, Gold Coast

DUNCAN, Ms Lyn, Clinical Nurse, Brisbane South Community Nurses Branch, Queensland Nurses Union

JANKE, Ms Narelle, Nurse Practice Coordinator, Brisbane South Community Nurses Branch, Queensland Nurses Union

CROFT, Dr Grace Rita, Assistant Director of Nursing (Research), Mater Misericordiae Health Services Ltd

DEWAR, Miss Anne-Marie, Secretary, Oncology Nurses Group, Queensland Cancer Fund

ROACH, Mrs Jane, Brisbane President, Oncology Nurses Group, Queensland Cancer Fund

MASON, Dr Karen Ann, Member, National Executive, Australian Confederation of Paediatric and Child Health Nurses

NELMES, Ms Judith Ann, Director of Nursing, Mater Childrens Hospital

CHAIR—Welcome. The committee prefers all evidence to be given in public but should you wish to give any of your evidence in camera you can ask to do so and the committee will give consideration to your request. I have to remind you that evidence given to the committee is protected by parliamentary privilege and that any intentionally false or misleading evidence to the committee may constitute a contempt of the Senate. The committee has before it your submissions nos 763, 925, 723, 369 and 331. Do you wish to make any alterations to those submissions?

Ms Duncan—Can I make an alteration to the name on ours?

CHAIR—Certainly.

Ms Duncan—It is submitted by Brisbane South Community Nurses. We would like QNU Branch inserted after that. It was done under that auspice.

CHAIR—Thank you.

Ms Nelmes—Could I comment on a question you asked the previous group of witnesses about registration being the same across the board?

CHAIR—Can I ask you to put that on hold until later?

Ms Nelmes—Yes.

CHAIR—I would like each of you to have the opportunity now to make a brief opening statement. Ms Nelmes, you could include your comment in your opening statement or we can ask you about it later. I call on Dr Mason from the Australian Confederation of Paediatric and Child Health Nurses to make an opening statement.

Dr Mason—Our submission aims to raise awareness of how the current nursing situation is impacting on children's health care, particularly the health care that is delivered by nurses. There is so much emphasis these days on other vulnerable groups in the community that we feel it is really important that children's health remains a priority in this review of nursing. More specifically, we think it is very important that the diversity of clinical setting in which nurses work with children and their families is considered. They are working from home, from school, in the community and at various levels of acuity within hospitals, so nursing children occurs in a very wide range of settings. For all of these settings, children and their families have very specific health needs that can best be met by well-educated, skilled nurse specialists.

Our submission comments on the changing context of children's health care, where the boundaries between these settings are blurring and where the boundaries between illness and wellness are blurred. The submission also makes recommendations on how to improve nurse education in relation to the nursing care of children at both undergraduate and postgraduate levels. I am happy to make further comments on that at a later stage, but that is basically what we feel is really important about our submission.

Mrs Roach—As president of the Brisbane Oncology Nurses Group, I wish to thank you for the opportunity to represent the state-wide membership of the Oncology Nurses Group of Queensland. The written submission represents the views of nurses who care for people with cancer in Queensland. This includes specialist cancer nurses, domiciliary, generalist, beginner and experienced nurses from both the public and private sectors. We asked the nurses to address two questions. The first one was: what are the factors impacting on nurses caring for people with cancer? The responses were: the demands of caring for people with cancer in terms of dependency on nurses for emotional and physical support, the lack of acknowledgment of the uniqueness of cancer nursing, issues of ongoing education and the need for increasing expertise levels that are expected from their employers, no time for workplace education due to increased workloads and difficulties with distance for rural and remote nurses. Staff shortages and unreasonable workloads was another response, and increased burdens on experienced staff as preceptors was another. There are issues of 24-hour call for ambulatory centres for nurses, a lot of overtime and patients who are coming into hospitals now with a very high dependency level and that nurses need to be recognised for that.

The second thing we discussed was: what strategies do you think would assist in the recruitment and retention of cancer nurses? There were issues of debriefing, standardising training in cancer care and collaboration with the private and public sectors. We understand that Queensland Health has the brief to address health for Queensland, but there appear to be barriers between the private and public sectors and we want these to be addressed. An example is the transition programs for public hospitals in Queensland. The private sector has not been

involved in that. There were the issues of opportunities for education of nurses in rural and remote areas and basically the promotion of cancer nursing and recognising staff shortages and workloads.

CHAIR—Thank you. I now call on Dr Croft from Mater Misericordiae Hospital for her opening statement.

Dr Croft—I would like to preface this by saying that we did not have a scientific sample represented in these comments. The Mater hospitals are a group of four public hospitals and three private hospitals. We had representation from the clinical staff, a lot from nursing education and some from nursing administration. The comments, which are somewhat coloured by my note taking ability, are the following.

First of all, in addressing education and training to meet labour force needs, we felt that the marketing initiative for nursing needed to be strengthened and coordinated. There is existing evidence that targeting young students at grade 8 and below goes a long way toward initiating an interest in nursing and subsequently moving into the profession. We feel that there is a great need to increase the media's understanding of the structure of the nursing profession. Often they refer to an individual as a nurse when that person is not a registered nurse. Also, there is a great tendency to refer to people as nurses in terms of criminal activity, when it turns out that they are in fact assistants in nursing.

There needs to be a PR campaign to market the notion of nurses with advanced clinical skills, which is a paradigm shift from the way that nurses were looked at in Australia several years ago. The notion of advanced clinical skills in nursing has been shown to relieve some of the shortages in health care delivery in the USA. It has not been taken care of, or considered, in Australia. There are very few feelgood activities related to nursing in Australia. As a result, you find some behaviour consistent with what is known as 'oppressed group behaviour', and that is certainly not consistent with a profession.

In terms of education and training, I phrased a number of questions based on the pronouncements of the document, such as: should universities prepare students to assume roles in acute care situations? You will have noted that that is one of the recommendations from this hospital. My belief is that they should not; the student should have the knowledge and technical skills to practise both in the hospital and in the community. I think we do a disservice to the community at large if we prepare students to function in only one area. Another question is: should there be a fourth year attached to nursing education? You will appreciate that there are arguments on both sides of this issue. The arguments against it are cost and the fact that it might be a deterrent to recruitment. I would like to propose an argument in favour of it, in that the fourth year could provide for a better grounding in the arts and sciences so that people could be prepared to assume truly professional roles.

Another comment had to do with an increase in practice time. I feel that it should be driven by the purpose of the clinical practice. It should not be considered as clinical practice but as a clinical laboratory where learning can take place. As far as time goes, it really has to go back to the curriculum plan to see what the academic staff are hoping to accomplish by increased clinical practice—or any clinical practice—because the expense of the clinical practice placements is quite onerous.

Another comment had to do with experience with the realities of health care. It seems to me that if this is going to happen, it needs to be a placement, on an elective basis, with those students in their last term of nursing. In terms of subsidising post-basic education, you will appreciate that there is a great need for post-basic education in nursing. We recommend that there be some kind of subsidisation based on completion of a program. The last recommendation had to do with staff development money. I think that we need funds not only to provide the education, but also to release the staff to attend the education sessions.

Ms Nelmes—I wanted to comment about the national registering body issue that was brought up. Having worked in many states, I feel strongly that there should be not only one national registration body but also one nursing act throughout Australia. The previous group brought up many issues, mainly to do with midwifery. I would like to bring to your attention some other issues that come up. In Queensland, registration for a mental health nurse is not separate from registration as a general nurse but in other states—I can only comment on South Australia as being my most recent experience—they are separated. My concern is: how come some nurses are able to practise in one field in one state without the same qualification as in another state or recognition that it is a separate field?

Also, if we are looking at nurses as they are, they are a very transient mob. I feel that we need not only consistency; we have to make it easy for nurses to be able to register across states. We need to have professional standards that go across all of the states as well. In my own mind, I cannot come to a conclusion about why it should be that nursing in different states within Australia means different things to different people. In fact, the Nursing Act in Queensland is quite old and does not clearly define what a nurse is. At the Mater we have recently been through this process of trying to work out what the act actually means. There are a lot of issues around that and it would be good to get that right at a national level, both the registering board and the acts that the nurses work under.

CHAIR—That is a very important comment and we appreciate it. We have just heard previous witnesses—I am not sure whether you were here to hear them—telling us of similar concerns. The mutual recognition for registration means that, for example, you may be qualified in state A to a lower level but you can go to state B where the requirements are different but you do not have to achieve them because you have just been given an automatic tick in registration. I think those comments are particularly useful. Thank you.

Ms Nelmes—Also, the process of registering in different states is really quite difficult for nurses. Each state asks for a different set of documents and they are large and voluminous. Also, the registration fees for nurses within each state are vastly different. Victorian nurses pay—I am not sure of the exact amount—a small amount. In South Australia it is almost double that amount. In Queensland it is somewhere in between.

CHAIR—Tasmania tell us it is more there because they have fewer nurses.

Ms Nelmes—That may well be the case.

CHAIR—I am interested in those comments, too, because we have all been given to understand that the application for registration from one state to another is not really any great burden. You are suggesting that we should add a caution about that: it can be bit onerous?

Ms Nelmes—I am mainly talking from personal experience in recently transferring my registration from South Australia to Queensland, and the difficulty that I had in getting my mental health qualification recognised when I had a university degree in that area.

Ms Attenborough—Thank you for inviting us here this afternoon. I will give just an overview of the submission. Child Youth and Family Health have been providing a service to Queensland families for around 100 years. Traditionally, the services have been provided with a low budget which has not been increased through the 20th century to the 21st century. We can only speak on behalf of the area that we work in. We would like to make the comment that we are a material resource poor area. We are committed to the provision of quality service, however, even though our venues and resources leave a great deal to be desired. I quote from a customer that came last week to a clinic. He said, 'My wife and I could never have expected to receive such an excellent service as we have received today. But let me ask you: how can you possibly work in this building?'

On the human resource level, apart from the salaries there is no backfilling for nurses on leave, unless it is long service leave or cost neutral. This means that sick nurses tend to report for work—and work, sick—because there is no-one to relieve them. There is an expectation that after-hours services be provided, but the nurses are not paid for this work. Instead, the system used is time off in lieu. If you are lucky, you can find a time that is convenient for both you and the organisation to reclaim that time. When you do, your work accumulates and therefore you wonder whether you have done the right thing by taking the time off. The easy thing to do therefore is just to forget about taking TOIL at all.

We mentor university students without support from clinical facilitators. At the same time, the universities are continually asking that we increase the number of students that we have through our service. Nurses who work in hospitals have a good system. The university pays for clinical facilitators, but we do it for the love of it. It serves to increase our heavy workload, but we do it because we are committed to the students that come through the service. We are also committed to increasing our own qualifications at our own personal cost. We are not sure whether we will be rewarded in the end, and most of the time we are not. The cost of nurses to obtain the qualification to work in child health is around $10,000 to $12,000. Unfortunately, the qualification is not recognised on the annual practising certificate, so that is one area that we would like to have a look at too.

So we are resource poor but we are happy—we are not. We have one nurse who intends to retire several years before she would like to, and I think she sums up pretty well what a lot of the nurses are thinking. She says, 'I've had enough. I've had enough of the poor pay, enough of the poor conditions, enough of the continual embarrassment about the lack of resources and the climate of bullying within the organisation.' She says, 'I've had enough. I'm not stupid. I'm out of here.' Sadly, the opinion of this nurse reflects the opinions of others in our health service district and the profession loses a nurse because she intends to leave early.

CHAIR—Thank you. Ms Duncan, would you like to make a statement on behalf of the Brisbane South Community Nurses Branch, QNU?

Ms Duncan—Yes. We would just like to point out that the issue and recommendations related to this submission have been developed by community health nurses—mainly aged and

adult health nurses, child, youth and family nurses—who actually work at grassroots. From the nine recommendations that we made in our submission, the members believe that the priority issues are (1) the establishment of a Commonwealth senior nursing officer within a nursing advisory unit, which would address issues such as standards of education, standards of nursing practice and a national registration; (2) the recognition of professional status addressing issues such as, but not limited to, remuneration, flexibility and career structure; and (3) recognition of the community nurse and the primary health care philosophy. Community nurses provide early intervention prevention health services. The credibility of these services, as well as the ability to continue provision of these services, is constantly undermined by the need for post-acute services. Strategies to improve recognition include, but are not limited to, the National Health and Medical Research Council encouraging and supporting research into primary health care and also a quarantine of funds for community health services.

And (4) is the lack of vision and planning. There are mixed messages being given about the future of community health. It is believed that there is no real understanding from decision makers on the purpose of primary health care and community health services. Politicians need to fully understand primary health care principles and philosophy in order to make informed decisions regarding health. The planning that is done is not readily translated into the real terms because of financial constraints. There is a general feeling that at times plans are not implemented because of political reasons and vote catching or retention. In our closing statement we recommend that the federal government ensure that appropriate resources are made available to community nurses to effectively and efficiently provide quality care through primary health care and interventions.

CHAIR—Thank you very much. I have to go and make an urgent phone call, I am advised, but Senator Knowles will now take the chair for a few minutes.

Senator WEST—You are a group of differing specialty areas. What career structure is there for you and how much of a problem is that?

Ms Duncan—I think a lot of the career structure is going back to the old thing that if you want to be a manager there is a reasonable career structure but if you want to stay in clinical you cannot go much above, really, level 2. There are some level 3s but they are becoming less and less, and that is a concern.

Senator WEST—Is there any recognition for the number of years you spend in a specialty area?

Ms Duncan—No, there is not.

Dr Mason—In Queensland we do not really even have the term of clinical nurse specialist. In other states it is a title that people use, whereas in Queensland it really does not exist. People can have great experience. Perhaps they are employed as a level 2 nurse and they are practising at a very high level of specialisation in their area but there really is not a mechanism in the career structure to acknowledge their expertise and skill. The only way they have to go is to apply for one of the very few level 3 positions that are around and, as my colleague says, they tend to be more management than clinical focused. The other thing that people do is move into education and other areas like that. So they are lost to the clinical area because they are looking to ad-

vance themselves and there is not a way of them getting appropriate recognition for clinical expertise.

Ms Duncan—Or for education. If you go ahead and do your masters or your postgraduate degrees, there is no recognition of that, either.

Senator WEST—You are all working in areas that, as a crude and a bit of a rough generalisation, would not be considered sexy. You are not in the areas that appear on *All Saints* and those sorts of things. What incentives are there for others to follow the career paths that you have followed?

Ms Nelmes—Love of the job.

Senator WEST—Does that pay the mortgage?

Ms Nelmes—It doesn't, but I think that it keeps a lot of nurses in their jobs. I would make a comment on the career structure. It is not only up to level 3; it is beyond level 3. There is a move within Queensland that level 4 is not necessarily an important level for nursing and you go from level 3 to level 5. But there are problems within that. Say within the public hospitals within the Mater there are maybe 80 level 3s but there are only two level 4 positions, how you get to act up and get experience in developing your career to a level 4 and then a level 5 is very limited.

Senator LEES—What is a level 5?

Ms Nelmes—A level 5 is a director of nursing. A level 4 is an assistant director of nursing. There may be other titles within other organisations but this is what we use within the Mater. A level 3 is either a clinician or manager.

Senator WEST—Nurse unit manager level?

Ms Nelmes—A nurse unit manager, yes.

Senator LEES—We heard at one of the previous hearings of a move in New Zealand where they are moving towards a 'specialist nurse practitioner'. An example given to us was 'neonatal nurse practitioner'. Where would that fit? Would that be about a 4?

Dr Croft—No, 2-3.

Ms Nelmes—No.

Ms Attenborough—Possibly 2.

Ms Nelmes—It may be a RN level 1 or level 2. A clinical nurse is level 2 in Queensland.

Ms Marriott—So what would attract someone to this area of practice? Within the level 1 nurse category there are eight pay increments. Within the level 2 nurse category there are four.

So you can just get to be up to a level 2.4 unless you become a level 3. If you remained as a level 2 nurse for 20 years you would never advance beyond level 2.4. Even if you paid a fortune of your own money to obtain additional qualifications, there is no ability to get 1c increase in increment beyond that level 2.4.

Senator WEST—Is it possible for a level 2.4 to be earning more than a level 3?

Ms Marriott—Yes, if there is a system of penalty rates for after hours.

Ms Nelmes—Most level 3 positions work Monday to Friday, from eight to five. In an acute setting, in public or private hospitals, level 2 positions work all shifts—earlies, lates and night duties—every day of the week, so they always earn more than a level 3, which is fairly inconsistent in itself.

Senator WEST—With level 2 having a lower level of responsibility than level 3.

Ms Nelmes—That is right.

Dr Mason—That is not the case in the community though.

Senator WEST—Tell us about the community.

Dr Mason—My colleagues in community child health work from nine to five, Monday to Friday. Ms Attenborough spoke about the issues of after-hours work but, for them, it is flat. There is no variation whatsoever.

Miss Dewar—Taking up Senator West's comment that it is not sexy, I think you are right. A lot of nurses said in our submission that there are far more attractive positions to take—that are not necessarily nursing—that make for an easier life for them, when you are not remunerated, your career structure is flat, and you have no reward for education that you might undertake.

Ms Janke—Nurses seem to be set up with a range of skills. It is much more lucrative for nurses to move into project management positions. Within our own area, we have a position that is being recruited to at the moment. It is predominantly nursing—leading a team of nurses—and it has gone up as a professional level, which means it will be remunerated at a higher level than level 3. If a level 3 nurse got the position, they would be paid as a level 3, but a professional person would be paid at a PO4 level, which is slightly higher.

Dr Croft—One of the greatest problems is that there is a reward for longevity to a certain point, but there is no reward for excellence. There are no merit raises in the system. This makes people who have been in the same position for, say, five years wonder about what the future holds for them. You can probably tell from my accent that I was not born in Australia, although I am an Australian citizen. Many of the personnel policies in large hospitals in the USA have at least five levels of bedside nurse. What the group here is saying is that, in order to progress both career-wise and monetarily, you have to move away from the patient, and yet the greatest need is at the bedside. That really needs to be addressed.

Miss Dewar—That is the irony of it all. We are delivering a service to clients, whomever they might be. That is the reason for our existence, at whatever level we are within that. The irony is that everything does not carry that as the focus.

Dr Croft—That is right.

Dr Mason—That is why people are leaving: they are not getting job satisfaction. That is what keeps them in nursing and, when they cannot get that, what is left? It was never the money.

Ms Nelmes—Mater Children's Hospital has no problem with recruitment of nurses. We are beginning to look at difficulty with retention of nurses. I have to say—having been in many others—that this is an unusual institution. Nurses have stayed in Mater Children's Hospital for 20 to 30 years, which has not been my experience in paediatrics prior to this. So we do not have that issue. I believe that other paediatric hospitals around Australia do not have an issue about getting nurses to work there. They are up to their FTE employment rate, but retention may become an issue over time.

Senator LEES—What is your average age?

Ms Nelmes—Again, this is an anomaly—I think you would find that other paediatric hospitals in Australia do not have this—but our average age is up towards the 50-year-old mark.

Senator LEES—So you are getting towards quite a significant problem.

Ms Nelmes—We are. Another anomaly within the Mater Children's Hospital is that the nurses have not gone anywhere else.

Senator LEES—So they have stayed there for a long period of time?

Ms Nelmes—It probably says a lot about the Mater—that they are committed to the Mater, to nursing—

Dr Mason—And children.

Ms Nelmes—and to children. But I think you find that people who work with children are committed to working with them.

Senator WEST—Do you think that issue is something common to maybe—I cannot generalise, but there is only a handful of top-class internationally recognised paediatric hospitals in this country?

Ms Nelmes—Absolutely.

Senator WEST—You have a range of cases you are treating. The issues and the cases you see coming through are exciting and different, varied, and it is stimulating nursing.

Ms Nelmes—From the in-patient setting, I think that is very true. We are really at the cutting edge and we have research that backs us up—whether it is medical or whatever. We can be right up there doing the latest things—benchmarking and the latest practices—and being seen as leaders in our field.

Dr Croft—In terms of recruitment and retention, I wonder whether we could talk about the skill mix on boards. One of the things that is happening—

Senator WEST—And maybe in the community too.

Dr Croft—In the community, as well. As you are probably aware, everyone is pressured by economic factors. As a matter of fact, some of the advances in health care, such as getting patients out of hospital more quickly, are unintentionally driven by that. Patients are a lot less likely to develop complications if that happens. It also saves the hospital some money. What is happening in that drive to, on the one hand, use professional skills more effectively but, on the other, to provide the bedside care needed is that levels of less prepared individuals are being put into the staffing pattern. It has been shown in article after article, and most recently in the articles by Linda Aiken in the USA, that when you have a poor skill mix and fewer than 100 per cent registered nurses, your patient mortality goes up. We also know that in the magnet hospitals program nurses tend to stay in employment in hospitals where the skill mix does not create a stress for them. We also know that, when there is a skill mix where nurses are required to supervise a lot of non-professional workers, their stress levels go up and the retention rate goes down.

Ms Janke—I think that some of the biggest issues that we in community nursing see are that we probably tend to generalise, inasmuch as we have right now staff who hold what we call portfolio areas. They need to be specialists in chronic disease self-management, diabetes management or asthma management. As well as that we are also now asking them to have the skills to deliver post-acute care. There is a vast variety of skills, I guess, that a nurse in the community is required to have so that they can deliver quality and safe patient care.

Senator WEST—So you are asking them to deliver more secondary care as well as perform their primary care role?

Ms Janke—That is right, yes.

Ms Duncan—Also, in the community you are at the level of independent practitioner because you are out there in the home. You have no doctor to ring up who can be there in five seconds flat, so there has to be a very high level of knowledge.

Senator LEES—Does this extend to aged care as well? Do you see a lot of elderly people in your normal working day?

Ms Janke—Predominantly, the focus of our services—and I am speaking for the adult team of nurses now—is very much on the elderly and young disabled. We see a huge variety of issues but, yes, we have been mostly involved with care of adults. However, that is going to be changing inasmuch as in very recent times we have taken on post-acute care. We are moving back into providing wound management and that will probably move on to things such as

intravenous therapy. I guess it is a matter of what takes priority, and, as community nurses, we fear that we are going to see post-acute services becoming more and more a part of our role and taking over some of that primary health care—the early intervention prevention type work that we have been able to do in the past.

Ms Duncan—I guess just one point is with the early discharge where it is supposed to save hospitals money. The money does not flow to the community. They are saying, 'Do this extra work,' but we have to drop something to do it. That is a real issue and a real concern for a lot of community nurses.

Senator WEST—And you would be dropping some of your preventive primary care which—

Ms Duncan—Preventative measurements; some of our assessments of the elderly where we can actually get in and do preventative measures such as falls prevention and things like that.

Senator WEST—Which is actually going to impact back on the hospitals because they will have more admissions.

Ms Duncan—This is where we are coming into the lack of planning and vision for community health. People do not have an understanding of preventative measures and how it can help in the future.

CHAIR—Can I ask Child, Youth and Family Health to follow that question of Senator West? Is it the same for you vis-a-vis changing your specialty and picking up on the early out of hospital?

Ms Attenborough—We are starting to look more at very high-risk clients. The complexity of the cases that we are dealing with now is more than we were dealing with in the past. The resources have been allocated to some parts of the state but not to all, so there are a lot of nurses who are doing home visiting services to complex families who do not have extra funding for those services. It is impacting on the fact that the nurses are having to upskill. When you go into child health you drop some of your acute nursing skills because they are not necessarily needed. But what we are finding now is that those skills are having to be rehoned again, so you have nurses who have to retrain in various areas. There is a lot more pressure put on them to make decisions relating to the safety of children. It can be in an area where it is fairly instantaneous and there is also crisis intervention. We are not an acute service, but we are being asked to be an acute service.

Senator LEES—So you are seeing chronically ill children as well as children who have been released early from hospital.

Ms Attenborough—Yes, we see the variety. A lot of the chronically ill are still being cared for by an outreach of the hospital or through the hospital but we do see them.

CHAIR—Ms Marriott, did you want to add anything at this point?

Ms Marriott—No, only to say that most of our nurses work across those areas of generally nought to four years and that includes more of that high dependency, acute, more complex cases. There are nurses who prefer to specialise in the pre and primary school area and another group preferring to specialise with young people in high schools.

Dr Mason—I would like to make a comment on that and we did address it in our submission. I think this whole area of superspecialisation within children's health care is an issue. I practised as a generalist community child health nurse in Central Queensland where my range of practice was from prenatal classes through to high school work. I covered the full range. In the cities we tend to be seeing much more of the zero to four and this kind of dividing up. It has implications for education as well as the sharing of these roles.

The other thing that is happening in relation to the skill mix is that some health services are setting up their children's health programs across acute and community settings. They are encouraging their nurses, whether they are working in the children's ward or in the community, to move across between programs. This is one way that they are upskilling the community people and vice versa. Certainly in some of the country areas this is what they are doing. Exactly as Vicki said, because of where people are at with their skills and their expectation of what it is to work in the community in a hands-off kind of style, this is creating a lot of stress for people. Particularly in children's health care where there is so much change going on in the context of practice and the priorities in responding to government policy with families first programs and this sort of thing, with the emphasis on child protection and all that sort of stuff, the issues of children with disabilities and chronic illness really does not hit the ground in community child health very much at all because they are being driven by these changes in our health directions towards child protection. So there are holes and cracks in the system that children and their families fall through. We hear about continuum of care and all of this kind of jargon but it is not happening.

Senator KNOWLES—I want to come back to the marketing of nursing, as so many people have raised this issue. I think it is the Mater submission that talks about promoting nursing as a profession to young students by going to primary and secondary schools. The primary element is an interesting addition. But why is that not happening now? It seems such a fundamental issue that should be happening. It should be included in vocational guidance. It should be all the different aspects of nursing, all the way through from aged care to paediatrics to oncology, and all the different issues. Why is it not currently being done?

Dr Croft—I will respond with a question: who recruits? If education for nursing is available at the universities, is that going to be relevant to a year 6 student in primary school? I think that as a national resource—and certainly the nursing work force is a national resource—there needs to be some incentive towards recruiting, whether it is done through a professional organisation, which I think would be the ideal way if you have a strong professional organisation, or through the state health department. The idea of recruiting into nursing is another one of these things that has fallen through the cracks. When you look at the advertisements for university nursing education, they come out prior to registration time, they show attractive young women who are probably 16 or 17 years old, but by that time a lot of people have made their career choices.

The other thing that has happened in the USA is that there is quite a bit of collaboration and sometimes contention between the professional nursing organisations and the way that nursing

is depicted in the media. I can remember one of the things that happened was that program about Vietnam and a nurse—*China Beach* was the name of it. They received commendation from the American Nurses Association for the way that they depicted nursing. On the other hand, several other groups have been chastised or criticised by the American Nurses Association or the given state nurses association for the way in which they depict nursing. Any of us who watch television after seven o'clock at night could certainly name programs in Australia that do the same thing. They are not all Australian programs, either.

Senator KNOWLES—That is right. What you are saying is correct, but surely the same applies to every other discipline: someone needs to get to the students at an early enough age so they can decide what subjects they need to go on to university to do that or that or that. The same should apply to nursing.

Dr Croft—There are not shortages in all disciplines. This is driven by the nursing shortage. When there was a shortage of teachers, which I do not believe there is today, the teaching organisations attempted to recruit.

Senator KNOWLES—How does that correlate with what we are being told all the time: that the schools of nursing are oversubscribed with those who have actually chosen nursing as a first preference?

Dr Croft—That the schools of nursing are oversubscribed?

Senator KNOWLES—That is what we are being told—with first preference.

Ms Nelmes—I heard that comment this morning and I had to wonder whether people are not using nursing, because of its low entry score, as a vehicle to get into the academic career they want to get into. You do not need a very high score to get into nursing at a university. They do a year of that and then transfer on to whatever subject, course or career they want to take on. It is about the quality of people whom we recruit, about whether they really want to do nursing and whether they understand what nursing is—because it is not what I thought it was.

CHAIR—Ms Duncan?

Ms Duncan—With the big picture we need to do all that, but I think it goes back to the little picture. The majority of nurses I know will not recommend nursing to younger women, they will not recommend it to their daughters—they will not recommend it to anyone. I will not recommend it, because you are being bullied and you have low pay—you have the whole works—so why would you recommend it to other people, especially to young girls? I think that is an important point.

Dr Mason—My other hat relates to my teaching at Australian Catholic University, which is a national university with schools of nursing in three states of the country. Our situation is different on each campus in relation to applications for our undergraduate programs. That is certainly so in Queensland, where we oversubscribe with first preferences every year, and our students do very well and are very employable and desirable. My concern is that graduates—and I worked at Central Queensland University for a number of years as well—leave; they do not stay very long. Especially when moving into an area where there are many new graduates, it is the people

with a little bit more experience that they need to look to for support, and they are not there; they burn out very quickly and they give up.

Certainly, I can only speak from the ACU's perspective in relation to our students here in Brisbane. We do very well, and they finish very well and are very employable. But they come back and they talk to us about the despair. We have all this stuff in the literature about reality shock and, therefore, it is the university's fault, because we are not preparing them properly for the real world, and all this sort of stuff. But I just do not know how else we can improve the reality for them when they go out there. They want to go out there and care for patients and I get telephone calls from people saying, 'I just can't do it. I haven't done a good job today. I haven't finished this and I haven't finished that. I want to do a good job in caring for my patients, and there is not enough time et cetera to do it.' That is why they are leaving.

Mrs Roach—Last year I was on a panel for the Nurse of the Year with the Queensland Cancer Fund and this issue was raised. One of the questions we put to the finalists was whether they would recommend nursing to other people. I was quite disappointed in the reaction I got from the older nurses, if I can say that—I am starting to fall into that category myself now a little bit—as they were the ones who said that they would not recommend nursing. I feel that nursing has a lot to offer. There are many parts of nursing that, when I was training, were never offered to us. The profession has grown a lot into all the different specialty areas, and I feel it is very sad that we are not marketing it as well as we should be doing.

One of the girls I work with is in research, and she trained in the United States where they are organising a mentoring program. They are asking nurses who have trained in a particular hospital whether they would be mentors for the new nurses who are coming through. That seems to be a strategy that is starting there, to, as you say, support younger nurses and try to keep them in the profession. I think something like that would be good.

CHAIR—We are getting to the point where we are running out of time. I am sorry to interrupt you, Mrs Roach. I appreciate that we have a large panel and you are doing splendidly. We wanted to get through as many witnesses as we could, and so it means that each of you have had to be brought into a panel. Can I please ask you now to keep your answers brief? Senator Knowles, you have the call.

Senator KNOWLES—It is an important area that we are looking at here. Ms Duncan, you say that you are worried about bullying, and we were talking about this with the previous set of witnesses. Harassment in the workplace is illegal. For the life of me, I cannot understand how such bullying cannot be eradicated by the management of any institution. Why is it still prevalent in nursing when it has been scrubbed out elsewhere?

Miss Dewar—I suggest to this committee that management in nursing is struggling in so many different ways. Bullying is in the nursing workplace and bullying has been in the nursing workplace certainly through the whole span of my career. A lot of the strategies we need to put in place for nursing need to be targeted at the management level. They have a whole new set of rules to play by and no-one has told them the rules or how to do it.

Senator KNOWLES—Or how to deal with it if the management are the perpetrators.

Miss Dewar—It comes from all levels.

Dr Mason—There are processes in place called PP and R, but staff tell you all the time that they are toothless. People constantly promote people, move people around and make great recommendations about people, to move them on. I think that this is a real issue in relation to management, for people to have the skills to do proper peer review and performance planning and review. It is a weakness in nursing. Nurses do not like getting or giving feedback. I coordinate postgraduate courses and it is very difficult to get my students to get feedback on their clinical performance. People do not want to know. It is part of our maturity as a discipline for us to move to a stage where we can give and receive professional feedback about our performance and respond to it without taking it personally and turning it into personal attacks. It is my view that it is a measure of our immaturity as a discipline.

Ms Nelmes—Even though there are a significant number of people who would say that they would not recommend nursing, I also believe there are a significant number of people who would and who are committed to it as their career. I had a previous career in the financial world, and I have to say the issues are the same. I am not convinced that what we are looking at is not a trend of modern business, rather than a trend in nursing—that is, bullying, recruitment, retention and other issues that have been brought up.

Dr Croft—Or is it the status of women?

Ms Nelmes—Again, that may be it.

Senator LEES—I have some general administrative issues. As you have prioritised what you think we need to do, I have been interested to see that quite a few of the issues really do not need a lot of money. One that has been brought up previously is how all of you relate to each other. Say you have a child in a cancer ward who is released on early discharge over to there, who maybe then goes back to a child nurse. How does it work in Queensland? Is it all computerised? On the day of release, can you quickly pass them—

CHAIR—*Hansard* should note cynical laughter at this time.

Senator LEES—It is an issue of great frustration when paperwork does not follow people and when paperwork is lost. Can I have some comments on the Queensland situation?

Miss Dewar—The paperwork is just one of the few issues relating to those sorts of things. We have early discharge programs now, where a child is released from the Mater Children's Hospital—or wherever—for cancer care in the country, and the nurses may have no experience in administering chemotherapy or in caring for a child or an adult who has received chemotherapy. So paperwork is one issue, but there are all the educational matters that relate to the transfer as well.

Senator LEES—This is what I was getting to. How do they actually know what is needed? What are the processes of education or computer courses or updating skills? People seem to be released earlier and earlier because of cost-saving measures, when all you may be doing is seeing people go back through the doors of the hospitals more often, as they strike other problems in the community.

Senator KNOWLES—Additionally, is there a check before the person is released as to whether that infrastructure is available to them?

Ms Nelmes—I do not believe that Queensland is as well coordinated as other states. They are certainly not as advanced in faxing to GPs on discharge, in electronic discharge summary, or in using the electronic tool within the hospital that can get that information out clearly and quickly. It seems to me that a lot of services do not talk together as well as they could do.

Ms Duncan—It is interesting: we have just started putting discharge liaison nurses back in the Mater and at PA. They were taken out about five years ago. This is just another really good example of the whole lack of vision and planning.

Senator KNOWLES—Is the role of the discharge nurse to check that all the ducks are in place for when they go out?

Ms Duncan—Yes.

Ms Janke—However, the role that they are going back into now is going to take on a slightly different look, I understand, to how it was previously. Another point that we should note here is the part that the GP plays in this whole continuum of care. One of the issues for us, especially in the community, is that we try to reduce duplication of services wherever possible. Because a lot of what we do is regarding assessment of people in their own homes or in their chosen environment, we are wanting to work a lot more closely with the GPs that see these people, because with the new MBS items there is a health assessment item number. We seem to have continuing problems where a GP may do a health assessment, or a GP practice nurse may do a health assessment, and then refer on to our services for something that we can offer, maybe home care. They will not in some circumstances share the health assessment with us, which then means that we go out and do another health assessment. Or we receive a health assessment from the GP where a number of issues have been highlighted—the person may have had a fall six months ago, or whatever the case might be—but there has been no follow-up from the GP practices with regard to management of whatever the issues might be.

Senator KNOWLES—Apart from stupidity, does that stem from privacy concerns?

Ms Janke—I think that probably the privacy concerns are getting to be more and more an issue for sharing of information across all spectrums—yes, most definitely.

Dr Mason—It is also often down to individuals because, rather than processes being effective, certain individuals have very effective networks that overcome the barriers that the system puts in place. It works very well in some places simply because of the goodwill of the individuals who are involved who are prepared to go the extra mile for their patients or whoever. I think that is where the good stories are, where a lot of good things happen despite the system.

CHAIR—There are two things I would like to say as we conclude a very rich day, as ever in good old Queensland. Those of you who collect information, for example Child, Youth and Family Health, Confederation of Paediatric and Child Health Nurses, oncology, community health workers: you no doubt collect a lot of information, files on patients. I am dying to know

where you keep them. Do you have a room or a base or a box under the bed somewhere? Do you all work out of a building?

Ms Janke—We do have a database in Community Health.

CHAIR—Do you have a building called the Community Health Centre?

Ms Janke—On the south side of Brisbane, we have three geographic areas. They are Coorparoo, Mount Gravatt and Inala. Inala has a subcentre as does Mount Gravatt.

CHAIR—I do not think I want to get into that sort of detail at this time. What I wanted to know is: what do you do with the information, apart from file it? Does anybody research it? Is anybody interested in the data that you collect?

Ms Janke—That is one area where Community Health has fallen down in the past. We are certainly looking at making more inroads into utilising our data much more, to look at trends and things like that. It is a matter of getting an information system that we can manipulate to do that.

CHAIR—And/or see if you can seduce some tertiary institution to do a collaborative project with you. You have piles of wonderful data that is not really being incorporated into the research arena or properly analysed—no different, in fact, from general practitioners who have data so rich yet at this stage largely beyond analysis. We do have to finish. I congratulate you all on sticking in there when I listen to what you have had to say this afternoon. Earlier in our hearing we had one nurse who said, 'But one of the things I like about nursing is the passion I had to do it in the first place, and I've still got that passion.' Is that true of any of you?

Ms Marriott—Yes, unfortunately!

Ms Attenborough—That is why we are here!

CHAIR—I think that is true, and I think that it is the other side of the story: everyone is giving us a litany on the problems, but not too many people are giving us a litany on why people stick to nursing—why you actually love it; why, despite poor recognition, low wages and everything else, you stick at it; and why, after 25 years, people are still in children's nursing et cetera. I think it is lovely for us to be reminded that you are still there and that, yes, you are still passionate.

Miss Dewar—I think the reason that a lot of us stay is the gratification you get from your clients. It is your client base where you get gratification. Sometimes it comes from your colleagues and it rarely comes from the management. I do make apologies. I would just like to say with regard to what Jane said about nurses not wanting to nurse that there were 53 entrants this year for the nurse of the year campaign. That still says a lot about what nurses think: if 53 of them are prepared to fundraise and lecture in their spare time, that is incredible.

CHAIR—We have heard a number of contradictory points. Some witnesses have told us that one of the challenges is that they feel they are not respected or valued by the people in the community, particularly by patients. Your contribution this afternoon does remind us that there

is a lot to really value and care for in this great profession. Thank you. The committee stands adjourned until tomorrow in Adelaide.

Committee adjourned at 4.58 p.m.