COMMONWEALTH OF AUSTRALIA

Official Committee Hansard

SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Reference: Nursing inquiry

WEDNESDAY, 27 MARCH 2002

ADELAIDE

BY AUTHORITY OF THE SENATE

SENATE

COMMUNITY AFFAIRS REFERENCES COMMITTEE

Wednesday, 27 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, 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

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VAN LOON, Dr Antonia Margaretha, Director of Development, Australian Faith Community Nurses Association 739

ZUCH, Mrs Antonia Wilhelmina, Member, Australian Nursing Federation 708

Committee met at 9.02 a.m.

BORBASI, Associate Professor Sally, School of Nursing and Midwifery, Flinders University

NEILL, Dr Jane, Senior Lecturer, School of Nursing and Midwifery, Flinders University

GIBSON, Ms Terri, Senior Lecturer, University of South Australia

HEARTFIELD, Ms Marie, Senior Lecturer, University of South Australia

JONES, Ms Kristina Nell, Lecturer and Coordinator of Master of Nursing and International Programs, Department of Clinical Nursing, University of Adelaide

MAGAREY, Miss Judith Mary, Lecturer, Department of Clinical Nursing, University of Adelaide

McCUTCHEON, Dr Helen, Acting Head of Department, Department of Clinical Nursing, University of Adelaide

CHAIR—The Community Affairs References Committee is continuing its inquiry into nursing. I welcome representatives from the Department of Clinical Nursing, the University of Adelaide; the School of Nursing and Midwifery, University of South Australia; the School of Nursing and Midwifery and associated institutions, Flinders University of South Australia. The committee prefers all evidence to be given in public, but should you wish to give any of your evidence in camera—in private—you can ask to do so and the committee will give consideration to your request. I remind you that all evidence given to the committee is protected by parliamentary privilege and any giving of false or misleading evidence could constitute a contempt of the Senate.

The committee has before it your submissions, Nos. 413, 755, 740 and 470. If none of you wishes to make any alterations to those submissions, I will ask each of you to make a brief opening statement and field questions. We are trying to get as many witnesses before the committee as possible, so we appreciate you all being prepared to be part of this panel-type session.

Dr McCutcheon—I am the Acting Head of the Department of Clinical Nursing. I want to make a very brief opening statement that refers the Senate committee to page 2 of our submission. In particular, I would like to emphasise that from our university's and our department's perspective, two of the most important things that we think need to be looked at and considered, in terms of nursing and nursing education, are that we need to ensure that we have an advanced, innovative and collaborative approach to the education of nurses, and that the promotion of clinically based programs that are well supported by the tertiary sector are vital. This allows students to have access to clinical experience while utilising the educational expertise of the tertiary sector. I would like to add that we consider it of vital importance that we actually have true, collaborative partnerships with industry, that these not just be token, but that we really do provide industry and the community with the nurses that they require.

CHAIR—Thank you very much. Would the University of South Australia make their statement.

Ms Heartfield—Terri and I are going to make a couple of points in relation to our submission, the first one being the desire to have a four-year undergraduate program. As our submission stipulates, it would provide the opportunity to address the requirements of contemporary nursing practice—which I am sure you are increasingly aware of, this being the last of your workshops—with its increasing technical practice and scientific rationale et cetera, engaged with the necessity for human skills that nurses very much need. Our submission proposes two models for how that four-year program might look, and they are a four-year program and a three-year plus one program. We would like to add to that the potential for a two plus two-year program. The results of national research in Australia have just affirmed the role of the enrolled nurse as a part of the core delivery of nursing in this country, so a two plus two model for a four-year program might actually be able to articulate and incorporate that second level worker.

The other issue we would like to speak to is increasing the opportunities for more places in university programs. The terms of reference talked about attrition rates, and our submission makes reference to those as well. Our point is that many of the issues that need to be addressed with regard to attrition rates from education programs and the recruitment and retention of nurses are part of workplace issues and not just education programs. The difficulty in being able to address those workplace issues means that if we are able to increase the funding opportunities for education programs then we may be able to bolster the numbers of nurses that are available. Clearly, for a number of reasons, of which we are all aware, it is difficult to retain nurses. It is not difficult to recruit them. We have no problem with recruitment to our programs; we fill on first preferences, our tertiary entrance ranks are going up, but it is retaining nurses once they graduate from our programs that we see as a key problem.

Ms Gibson—In closing, we would like to raise a few further points. With regard to education and training for future nursing labour force needs, we would like to reiterate the need for innovative, flexible and multiple models of enrolled nurse, registered nurse and post-graduate education within an articulated framework that enables multiple entry and exit points, all of which should, of course, include competency based outcomes. With regard to the interface between universities and the health system, in addition to the practices that we, at the University of South Australia, would argue are standard, such as collaboration with clinicians in the development and evaluation of curricula and evaluation of field placements, it is essential that funding continues to support the establishment and maintenance of clinical academic positions, such as chairs or professorial joint appointments. We currently have three of these.

A less recognised aspect of enhancing the interface is the positive impact of collaborative research. We have a university funded research centre, the Centre for Research into Nursing and Health Care, which is part of our school. It has a national and international reputation. We have been involved in some national nursing projects for the DETYA National Review of Nursing Education, as well as conducting the Australian Nursing Council project, the Revision of Competency Standards for Enrolled Nurses. We are also involved with local clinicians in a whole range of collaborative research activities that have contributed significantly to enhancing that interface between education and practice, and which have contributed to ensuring evidence based outcomes for practice and education.

As I have stated, we suggest that both funding of nursing research and support for it ensure quality practice and education in a number of ways, including improving the evidence base for practice, which is critical to positive client outcomes. We must also ensure that educational content is relevant to practice and it is also a key strategy in interfacing the two systems, along with other educational strategies that have already been mentioned.

The final point I would like to mention is with regard to retention and recruitment. Strategies to attract and retain nurses are very complex, as we probably all know, because they are located within social images of nursing as well as the economically driven demands of health service delivery. One example relevant to our university is the need to acknowledge the necessity for funding of re-entry programs in the university. We have been conducting an extremely successful re-entry certificate for registered nurses for a number of years. We have no funding support for that, which impacts directly on the students and the potential numbers for re-entry into the work force, because of the need for it to be a full fee paying course.

We would suggest that this particular program is also an illustration of where state and Commonwealth relations are not working in an effective way to support what already exists as a quality program. The state government recently made moneys available for hospitals to undertake re-entry programs which meant whole new programs had to be developed. They were not in existence, whereas we had an existing program which was a quality program. So I think there needs to be a better interface to enable quality programs which are already in existence in a whole range of areas to be funded. That is all I would like to say.

CHAIR—Where was that program based?

Ms Heartfield—At the University of South Australia.

CHAIR—Which part?

Ms Gibson—In the school of nursing and midwifery.

CHAIR—Which is based where?

Ms Gibson—At City East campus.

CHAIR—Do you work particularly with one medical or hospital institution?

Ms Gibson—No, we have clinical placements in a range of areas.

Prof. Borbasi—I would like to speak to our submission. We put in two submissions. One was purely from the school of nursing and midwifery and the other was in collaboration with some industry partners. I would just like to refer you to the latter submission, which is the collaborative one. I want to talk about some issues that are identified on page 4. Much of what I have to say will be a reiteration of what has already been said, but I do think we need to recognise that the shortage of nurses is a complex issue and not just a matter of numbers and that a range of factors have been identified as being capable of influencing the supply and demand of the nurse work force. In our submission, we have identified many issues that have been carefully deliberated. You are probably aware that it is quite a lengthy submission. We

have provided a sociocultural context to the current situation, and we have looked at strategies to address each of the concerns we have raised.

Fundamentally, we see that the current difficulties need to be addressed at two levels, and previous speakers have already alluded to that. One is about the workplace and the need to raise the profile of nursing and increase nurses' job satisfaction. The other concerns the education of nurses and the lack of sufficient funding and other resources in the area. In our submission and our executive summary, we address the first issue, which is related to workplace concerns. I will just go through a couple of those, if I may. We have a highly educated nursing work force now, and highly educated nurses want to be recognised by the system and to work as valued members of teams who are involved in decision making, rather than in subservient roles. So really the education of the nurse has taken off. We have modern nurses with exceptional knowledge and skills, and yet they are working in a system that has not changed for the last 100 years or so. That is making it extremely difficult for them to fulfil their optimum potential. Nurses at all levels should be more fully involved in health service planning and delivery and policy development. Rarely is their expertise sought out. We are working on a better career pathway, but it still needs work.

Professional scope of practice and health care boundaries need to be renegotiated. For example, the boundary between nurses and medical officers; the boundary between nurses and unskilled personnel, patient care attendants; and the internal boundaries such as specialisation and multiskilling need to be redefined in recognition of changing contexts—we all know that we live in a world of change and the health care system is in a state of flux—and in recognition of the knowledge and skills that modern nurses have. We contend that the nurse practitioner role should be fully encouraged and fast tracked nationally. Of course, in line with these developments, the status of nursing should be lifted through sustained well funded campaigns.

Then we talk about educational issues and, as Terri and Marie have already alluded, there are funding issues concerning education in the undergraduate and postgraduate degree programs. If I can go to another document, I would like to state that in Australia the number of places in university Bachelor of Nursing programs has halved in the last five years. But, over the same period, the TER score has risen to its highest level. The number of first preferences for nursing has increased and the attrition rate over three years is 10 to 15 per cent, which is the lowest rate it has ever been.

In South Australia, as we have already heard, both universities have filled their allocated places for undergraduates. At Flinders, the Bachelor of Nursing has been consistently overenrolled against the university target for the last four years. Although there are many choices for young people these days, in South Australia nursing still attracts students in sufficient numbers. There is an increasing cohort of students with very high TERs coming in, which is very pleasing, and there is an increasing number of graduate entrants. So, really, it is debatable whether there is an actual shortage of nurses—that is, those entering nursing—or whether it is rather a shortage of funding to allocate university places to nursing and, in the public health care sector, to employ nurses and provide the conditions which retain them. Once we have them in the system we need to be able to retain them in the workplace.

We contend that the number of HECS places allocated to nursing has probably contributed to the shortage of nurses in the work force. The funding to support the nursing work force and to

ensure that nurses have the incentive to stay in the work force, such as their continuing education, has radically decreased. The value placed on an educated nursing work force has been eroded. Moreover, as an outcome of the move to tertiary education, nursing clinical education—I think this is the key—has not been funded by either state or federal governments. We all know that nursing is a practice based discipline and ensuring the practical education is expensive. We do not receive dedicated funding for that. We seek federal government increases in HECS funded places for nursing students through direct allocation to universities in each state, and we ask the federal government through DEST to fund clinical education for preregistration undergraduate degree programs.

At state government level, we would like to see a promotion in cultural and structural change to retain registered nurses in the public health sector, and audits carried out to ensure that case mix derived funding to support continuing education is being used for that purpose. Postgraduate specialist education should continue to be carried out in partnership between universities and clinical agencies with funding from the state government managed by universities. We reiterate that, yes, universities and health agencies should develop stronger collaborative links, particularly to support new graduates in their first six months and in continuing postgraduate education.

If you will bear with me, I want to say a couple of other things. We all appreciate the opportunity to be able to voice our concerns to a committee such as this. We would like to see nurses' access to postgraduate educational opportunities reconsidered. Specialist nurses are needed to staff specialist units, such as intensive care, and teach other nurses and medical officers undergoing training. Education providers in consultation with industry need to continue to develop innovative educational programs. There are issues surrounding aged care and rural and remote nursing, which we have addressed in the submission.

I want to reiterate what Terri was saying and that is that we need to increase funding for nursing research so that nursing effectiveness becomes overt and as it becomes overt, obviously, the knowledge and skills that nurses have will become more public. The nursing contribution to research and development and enhancing the use of evidence to support practice has never been recognised in the health sector and needs to be maximised. Funding clinical chairs and joint appointments go a long way towards addressing many of the issues raised. Clinical chairs are extremely important and very successful in raising the profile and status of nurses and nursing, facilitating nurses' contribution to policy development, improving the collaboration between the service and education providers, promoting research in nursing and providing role models for the profession. So clinical chairs are extremely important and our submission talks about those issues.

To finish off there is one issue that I have been asked to mention. It is an issue that has been publicised quite widely, certainly in Adelaide in the last couple of days, and concerns indemnity for midwives. We have a group of undergraduate midwifery students and registered nurse students undergoing midwifery training who cannot go out on clinical because they do not have insurance. The insurance has been withdrawn. It is currently being renegotiated but an answer does not seem to be forthcoming.

Senator KNOWLES—Dr McCutcheon, I would like to start where you finished off and that is on page 4 of your submission. The very issues that you have raised are the ones that I had un-

derlined: an advanced, innovative and collaborative approach to education, promotion of clinically based programs well supported by the tertiary sector and more skilled nurses at the bedside. Could you elaborate on how you think all of those things can be achieved? On the second issue—the promotion of clinically based programs—what are you advocating? Is it more clinical time? Presumably, it is not a case of going back to where we were. I would be interested to learn more about that.

Dr McCutcheon—Can I say, for clarification, that our department specialises in postgraduate education. We do not have an undergraduate program, not because we do not want one but because there is no funding and there has been opposition to us having an undergraduate program from the other two universities in this state. Our specialty is postgraduate education. The advanced, innovative and collaborative approach that we use in our department, that works exceptionally well, is that we have clinical experts to teach the clinical components of nursing education. That has brought the clinicians into the tertiary sector and it has taken academics from the tertiary sector into the clinical area. I am not saying that is not working in other places—they are doing it—but that is the fundamental principle that we base our whole program on. There has to be a strong relationship between our industry partners and the university; there is a sharing of expertise: clinical knowledge and theoretical knowledge.

The other thing is that we do not get any state government or Commonwealth funding. All of our nurses, and this year there are 288 enrolled in our department, are full fee-paying students. They pay full fees to come and study in this department because of the clinical focus of the courses—that is our feedback. To elaborate on what a clinically based program means: we have subjects that are very much about the practice area, we have subjects that are very much about theoretical knowledge and experts in both those areas come together and teach. As the students go through this postgraduate experience they see the true partnership between industry and education in terms of facilitating the learning experience.

Senator KNOWLES—Yes, that certainly assists. Thank you for that. Can I move on to the question about more skilled nurses at the bedside. It sounds like a motherhood statement and you would not be putting it in if you did not have just cause.

CHAIR—Further to that question: does ‘more skilled nurses’ mean more nurses who are skilled or better-skilled nurses?

Dr McCutcheon—Both. We know that there is a nursing shortage and I think Sally, Terri and Marie have articulated quite clearly the reasons for that. What we do have are graduate nurses coming from the academic environment to the bedside without the requisite skills to actually be able to function in a way that allows the industry to provide to the community truly a quality service. The problem has been that we move from a purely hospital based environment to the tertiary environment and I think to some extent we have swung too far in terms of the amount of time that undergraduates spend in the clinical environment. I think, and our department believes, that perhaps one of the reasons for that is this notion of a tertiary year and a semester. We know that, for example, undergraduates in the medical faculty do not go to university 26 weeks of the year. They are actually there for considerably longer. Perhaps one of the things that we need to look at is allowing undergraduate nurses the opportunity to spend more time in the clinical environment across the full year rather than just the academic year.

Senator KNOWLES—Interestingly enough, that has been put to us by a number of witnesses who have told us that the year is not well utilised and there is so much time that could be well spent focusing on clinical experience that is not being done now. The argument that some would use against that is that that is the only time they have got to be able to earn a dollar and yet there could be other ways in which they might be able to earn some money doing that and getting experience simultaneously. Would you like to comment on that possibility?

Dr McCutcheon—It is quite clear that we have got undergraduates who are working in McDonald's or wherever rather than working in the environment and culture that they are actually going to have their career in. Here in South Australia, and I know at the Royal Adelaide Hospital, they have taken on undergraduates as nursing assistants who have completed up to year 2 of the undergraduate program and they are being paid at that particular level, and that has been negotiated with the union, the Australian Nursing Federation. While there have been some teething problems with it, the actual undergraduate students who are working at this post-second year level of their program are anecdotally saying that they are starting to feel part of what is going on; they know what the hospital is like; they know who these people are. These are the things that the graduate nurses have to learn in their first year because they have not actually spent sufficient time during the undergraduate program in the environment and in the culture in which many of them are actually going to spend their working life.

Senator KNOWLES—Ms Jones and Miss Magarey, you are both signifying some interest in this. Do either of you have anything to add?

Miss Magarey—I certainly agree with what Dr McCutcheon said about the students not necessarily having the clinical skills when they leave the academic setting and they start their career in a hospital, which is where most of them actually end up working. That also contributes to attrition in that first year, and throughout their career, because they do not actually feel comfortable or confident in the setting where they have got to work.

Ms Jones—I would reinforce that. I also think that, because we have such a close alliance with Royal Adelaide Hospital in particular but with many of the other hospitals in this state, we are actually part of practice. We actually go into the hospital and are recognised as nurses even though we are still academics. It is easy for us to say that there are some issues and the Royal Adelaide really have started to address them by trying to facilitate some programs that allow them to actually be involved in the culture of nursing at an earlier stage.

Prof. Borbasi—There are certain things there that I take exception to, so could I respond to that?

Senator KNOWLES—You certainly may.

Prof. Borbasi—With respect, the University of Adelaide does not have an undergraduate program, so I think that the University of South Australia and Flinders University probably have a better insight into some of the issues that have already been raised. I would like to draw attention to the clinical program that we have in the School of Nursing and Midwifery at Flinders, which we have described in the submission. It is based on a model that we call dedicated education units. It has been developed in recognition that the hospital block placements that we used to utilise for clinical practice were not working too well. With our dedicated education unit

model we have developed collaborative partnerships with acute care centres and community centres, and we have students going out for protracted periods of time over the academic year.

Senator KNOWLES—For how long?

Prof. Borbasi—In first semester, they go out for two days a week, for 13 weeks. If they were in second year, they would be going out for two days a week, for 13 weeks. Third years would go out for three days a week, for 15 weeks. They have a practicum, where they can go to an area of their choice in the last semester of third year, for a prolonged period of time. The philosophy underpinning the DEU is that students go out and become known in the ward. The staff expect them, want them there and value them being there. The staff are involved in coming to the university and participating in workshops where we go through teaching and learning issues regarding preceptorship and assessment of the students.

CHAIR—Can I stop you there and ask Ms Gibson to give an answer to Senator Knowles's question. We will come back to more detail later and I guess we will have to give you the right of reply. Tell us what you wanted to add there.

Ms Gibson—In relation to the notion that more clinical experience is better in creating a better undergraduate product—for want of a better word—I do not think there is enough research evidence to show that more is necessarily better. I think that enhanced clinical funding means we could do some research and come up with some innovative ways of using our clinical time better. We know that there is not a limitless pool of money. We are all very well aware of that. I think that there are some innovations that could happen, where we could use our clinical time more effectively than we currently do. That may mean there needs to be a bit of rebalancing, maybe a little bit more. I am not disputing that, but I do not think that the argument holds up that longer means a better product, quite frankly.

Senator KNOWLES—Professor, could I get your particular comments on why you would oppose using the other 26 weeks of the year in greater emphasis on clinical practice?

Prof. Borbasi—I do not know that we are opposed to that notion. We feel that our graduates are at a level that would be expected of them at the end of a third-year undergraduate program. They come out of our program able to meet the ANCI competencies at a beginning level. We do not have any problems with that issue. We believe that the issue is at the other end, in many cases, where you have a health care system that is basically in crisis. We are here because there is a shortage in registered nurse numbers and therefore people are working much harder. The stress levels out there in the health care sector are very high. Then you get new graduates who come out and who are supposed to be nurtured, have role models and be shaped into a fully fledged registered nurse role, but nobody has time to do that. They are expected to hit the ground running. They are expected to come out and work at the level of a registered nurse who has been out for two, three, five or eight years. So we do not need to look at the education, as far as we are concerned. We are putting them out at a level that we are happy with, but it is what happens to them at the other end that we need to look at.

Senator KNOWLES—But isn't that surely the argument for utilising the remaining part of the year with more experience on the ground?

Prof. Borbasi—But one could argue that, in other practice based disciplines, there is an expectation that you put graduates out at a certain level and then they slowly become more and more competent through on-the-job experience and training programs.

Senator KNOWLES—But is that an argument then for a year of internship?

Prof. Borbasi—There are arguments for a year of internship. Some people are opposed to that and some people think that is an excellent idea. The service providers put forward that suggestion to go in our submission.

CHAIR—Senator Knowles, Ms Heartfield is looking for the call on your point.

Ms Heartfield—I have a couple of points that I would like to make in response to those previous comments. I will start with the graduate year. While that was mentioned in our submission, what we would like to see happen is that we maintain the capacity for diversity and what we do offer as nursing education pathways. I would hate to see that there was only one option available for how registered nurses might be educated. As I mentioned briefly before, I think that there are a number of ways that we could very effectively produce the level of nursing work force that we actually require, which may include a core four-year program. It may include a graduate year and articulation very closely with a second-level nurse. I repeat that it would be favourable, from our point of view, to actually make the opportunity for that diversity to still exist within a tertiary education system.

I want to make another couple of comments about how we use the year. Whilst I do not have the statistics in front of me, I could fairly confidently—and I suspect most of my colleagues would agree with me—generalise to say that the majority of nursing students are employed just about full time. Almost the majority of nursing students have domestic commitments which mean for them to be able to have a semester allocation for their university commitment allows them to engage in their private lives outside of university. While semesters do not mirror school holidays exactly, they are pretty close. As a core part of nursing students in this country are mature-age and predominantly women, that is an important issue.

We do try and facilitate fast tracking. We are looking again at opportunities to make that fast tracking more overt so that the student that wants to get in and out of an undergraduate program as quickly as possible can do so. But I think there is also a need to provide programs that allow people to live their lives and actually engage with this education of what it means to become a nurse rather than to try and accelerate this production of something that can hit the ground running, which is a term that I hear so often. Again, the comment was made in our submission that we expect our new graduates to be experts. There is an expectation that they will be experts when we are well aware that what previous graduates of hospital based programs were expert in were not necessarily the right things.

Senator KNOWLES—It is interesting because I think that a lot of people really want to focus on not necessarily making life more difficult for them or rushing them through the system but making them better equipped at the end of the day to fulfil not only their expectations but everyone else's expectations. At a time when, as you say, nurses are in a shortage, to a layman like me, it seems a logical thing to be able to give people experience at the same time as trying to back up the system with people who are genuinely interested.

Ms Heartfield—I have one more comment with regard to that. Clearly, it is something that is growing. It has grown very much in this state over the last 12 months very clearly in response to the shortage of nurses. It is the opportunity for nurses engaged in undergraduate studies to go out and gain some employment in predominantly hospital settings. We absolutely support that. The University of South Australia is actively engaged in that with a number of organisations. We have got stunning collaboration where there is not only paid employment but scholarship opportunities being put in place. It is really a delightful exemplar of the sort of collaboration that can happen.

CHAIR—Which institutions are they, Ms Heartfield?

Ms Heartfield—St Andrew's Hospital and Griffith Rehabilitation Hospital are two that come to mind.

Ms Gibson—I cannot remember the others.

Ms Heartfield—Certainly we can provide more detailed information about those two to the inquiry after today. The point that I wanted to make is that this is fairly new. Clearly we are, from an educational point of view, very conscious of very carefully monitoring what happens with those programs, because we are well aware of the fact that it is a service need that is driving this, but that we are coming with an educational priority as well. This is just the beginning and we are wanting to monitor it really carefully to see whether it is a productive way to go.

Senator KNOWLES—I want to come to the issue of funding. I think it was you, Professor, who mentioned the words 'lack of sufficient funding'. In your submission, you talk about how DEETYA funded student places at universities must be increased and so forth. What I am looking for is how all of you feel about the possibility of the federal government liaising with the states—because my belief is that the states are the ones who know best what is required for that given state—or in some way getting a better outcome for the number of places that are available. It seems to me that what is happening is that some bureaucrat in Canberra sits in an office with no windows and decides that there are to be X places at this university and X places at that university and so forth; but this bears no relation to what is going on and what the requirements are in the hospitals out in the marketplace. I would like to hear from you as to how you think that the funding issue and the number of placements issue can be resolved in a satisfactory way to give better numbers and better services in the hospitals or out in the community, at the end of the day.

Prof. Borbasi—From my understanding of it—of course, the dean of the school would be better placed to answer that—the number of undergraduate places is determined by the university. So some person in Canberra will provide funding, presumably, to the university and then the university divvies up that funding to different schools or faculties.

CHAIR—Do you put in bids for more places to the manager of your university?

Prof. Borbasi—I am sure our dean has.

Ms Heartfield—Yes.

CHAIR—You have not actually said we need more places?

Prof. Borbasi—She has.

CHAIR—'She'?

Prof. Borbasi—Judith Clare.

CHAIR—But do you actually campaign for more nurses?

Prof. Borbasi—Yes. I am sure there is lobbying that goes on. Certainly we turn away prospective students, because we do not have the numbers of places.

Senator KNOWLES—But that is the lunacy of it, isn't? We are talking about a shortage here, and yet the courses are oversubscribed.

Ms Heartfield—Yes.

Prof. Borbasi—Absolutely. What she pushes for is dedicated funding and somebody who does some work force planning and says 'There are so many places that are needed in nursing undergraduate education. Here is the funding for them,' and so we get dedicated funding for nursing places.

Ms Gibson—I just wanted to pick up on the point about some dialogue between the Commonwealth and the state in relation to the nursing labour force statistics, for example, and how they pan out in terms of the educational places that are required. In South Australia, the Nursing Labour Force Planning Committee is managed through our Department of Human Services, and certainly the schools of nursing are represented at that. It has been an interesting committee in the sense that we give each other information, but nothing much happens with it because of the funding dichotomy, if you like, for want of a better word.

Picking up on your point, there absolutely has to be some kind of better dialogue that enables that funding to flow more effectively and be used more effectively. I am not sure how that can be accomplished—I would probably have to go away and think about that a little more—and I understand the complexity of state and Commonwealth relations only in a very small way. But I do think that there is room for dialogue and that it has to happen. It would be interesting to set up a group to try and look at that, with the people who have been attending that committee feeding in how they think the dialogue might occur to help facilitate that flow.

Senator KNOWLES—For a realistic outcome.

Ms Gibson—Absolutely.

Senator KNOWLES—Because the other crucial part of this is to have a realistic outcome as opposed to a wish list. We might want to have double the number of nurses but we know we are not going to get funded for double the number of nurses.

Dr McCutcheon—We are going through this exercise right now of trying to get EFTSU from the university for an undergraduate program. The university's response—and I am sure it is the same response that the universities give the other two schools of nursing—is: 'There aren't any EFTSU. You can't have them.' However, if one wheedles hard enough and goes to the right people, you can find out what the attrition rate for EFTSU across schools actually is. It is not easy information to get, because heads of department and deans do not want to give you that information. But our department has managed to find out that across the University of Adelaide, for example last year and for a few years back, on average there is about a 15 per cent attrition rate. They are students who enrol but pull out before the census date at the end of March, which means they are still funded for. Departments still get funded for them but they are not using their full student quota. The argument that we are trying to put to our university is: 'Please can we have some of them?'

CHAIR—Backfill?

Dr McCutcheon—We know that, on average, 15 per cent of the students drop out in any given year before the census date at the end of March.

Senator KNOWLES—What is your drop-out rate?

Senator WEST—What is the nursing—

Ms Jones—We do not have one.

Dr McCutcheon—We do not have an undergraduate program.

Senator WEST—But what about in your postgraduate program?

Dr McCutcheon—I think it is about two per cent. Because these are fee-paying students.

CHAIR—Why would you be wanting to pinch some of the undergraduate places of USA or Flinders?

Dr McCutcheon—Perhaps this is the time to respond to Professor Sally Borbasi. I think it is short-sighted for the other two universities to think that we do not keep up to date with what is going on in the undergraduate program. Our postgraduate students have come through these undergraduate programs. They tell us about the things that they are lacking when they leave, so we do in actual fact have quite a bit insight into what goes on in these undergraduate programs. I take on board everything that the two other universities say; I think they have raised very valid points. However, there is always the room for diversity, which is exactly what Marie spoke about. What we would like to do is develop a small undergraduate program initially, that will be evaluated at the end of the three years, to look at alternative models of introducing the clinical component of the nursing to the undergraduate student. This would be in collaboration with the Royal Adelaide Hospital and the affiliate hospitals that we work with. That is why we want to pinch some of the EFTSU that are actually out there because they are not being used when students withdraw.

CHAIR—Why not take Senator Knowles's proposal and go argue for more?

Dr McCutcheon—Well, we would like to do that as well, and we have tried. Certainly, we are putting forward a case to our vice-chancellor now that he needs to ask for more funded positions that can actually come to nursing. We sit in a big health sciences faculty that has a medical school and all sorts of things, and there is no undergraduate nursing program.

CHAIR—We have got far too much, it is far too interesting and we have got lots of senators, so can I ask you to keep your answers brief. We will try and give you all the opportunity to have a say.

Senator LEES—I will try to ask some short questions. Just to go back and look at the picture of where students are coming from, and how you are attracting them: is there any program in South Australia to go out into the schools to get these high-quality students? We have not found very much of one in other states. Could you very quickly tell us what you do.

Ms Heartfield—We run a very active marketing program which has been in place for at least five years within our school and we have a committee that works tirelessly across all levels of education in the primary and secondary sectors.

Senator LEES—What age would you start?

Ms Gibson—We have even had kindy children come in to have a look through, as part of the promotional program.

Ms Heartfield—I think it is kindergarten. We run a schools program where we bring them into our laboratories. We use it for our students to do part of their childhood studies, in terms of working with these kids, looking at what is health and what is nursing. That is probably the beginning point for our program, but that goes right through primary school and secondary school. That team of people is also involved in various professional activities and career expos, promoting at every possible opportunity.

Senator LEES—What was your TER score this year?

Ms Heartfield—Sixty-five is the minimum for this year.

Senator LEES—Do you have an idea of the average?

Ms Heartfield—I would be guessing.

Senator LEES—Prof. Borbasi, do you do promotional work out in the schools?

Prof. Borbasi—Yes, we do. We have an administrative person, part of whose role is to market to secondary schools, and we have course coordinators who go out and present. Flinders Medical Centre has recently introduced the notion of work experience for high school students, which is something that hospitals largely have not done before. That is a new innovation to try to attract secondary school students.

Senator LEES—Are you looking at years 10 and 11?

Prof. Borbasi—Yes.

CHAIR—Is that part of the vocational education training that leads into TAFE and an EN program?

Prof. Borbasi—No. This is work experience, to come to Flinders Medical Centre to have a look at the role of the registered nurse.

Senator LEES—What was your entry score?

Prof. Borbasi—The TER score for this year was 68.

Senator LEES—Could I ask each of you with a graduate program how many students you have in that program and how many of those are overseas students, and could I ask representatives from the other two universities how many HECS places you have and how many overseas students you have? If you want to take this question on notice, that is fine.

Dr McCutcheon—We have 284 graduate nurses in our postgraduate programs. We have a program in Bangladesh and a program in Sri Lanka funded by the World Health Organisation where we have 10 nurses each year for three years. We have nurses in Singapore, Malaysia, Canada and America in our doctor of nursing program. We have 62 nurses in our masters program. But the bulk of them are in our graduate diploma programs which are for specialties such as ICU, cardiac and gerontology.

Senator LEES—If you have some paperwork on that, could you pass that on to the committee?

Dr McCutcheon—Yes, we can give that to you.

Ms Heartfield—I want to make one point as the director of one or our international programs which are non-HECS based. We make our money out of those programs.

Senator LEES—This is one of the things that I am getting to. If we are now looking at lots of kids out there who are interested, presumably quite a solid base of non-school leavers in that mature age people are also interested, what is your capacity to increase, particularly given that both of you have substantial numbers of overseas students—I understand that you have some relationships with particular countries where you seem to get large numbers in—and given that you need clinical placements as well as university space? The shortage of nurses in South Australia stands at about 500, I understand—some say 800. If the committee wanted to make a recommendation about the need to go back and make sure that the universities—maybe all three of you—have an extra 100 places or whatever, what is the capacity to do that?

Ms Heartfield—The problem area of that capacity is in how we define and enact clinical placement. You have heard the debates about desires for what it might look like, and they are limited by the places that are available within health-care agencies for nurses to engage in nursing practice. My opinion would be that that is really the only limitation. In terms of staffing availability, qualifications, skills et cetera, we are well-resourced. The clinical placement is the problem area. There is a lot of scope to be creative and redefine what that might look like.

Senator LEES—Do you cooperate; do you check with Flinders as to what time they are sending students out?

Ms Gibson—Yes. We cooperate on field placement; we have a collaborative model for that.

Prof. Borbasi—But we have different models.

Senator WEST—But if you are going to be sticking postgraduates into the same wards where there are undergraduates, you are going to create pressures. I would presume that, in some of your specialty areas, you must have some collaboration. There is no way that a ward of any sort would want a whole stack of postgraduate students as well as undergraduate students.

Prof. Borbasi—Postgraduate students are usually already employed within a hospital, so their clinical component would be part of their employment.

Ms Jones—Their normal practice.

Senator WEST—Apprenticeship style.

Prof. Borbasi—Yes.

Senator LEES—I am wondering what numbers Adelaide are looking at in terms of the HECS places they are trying to wheedle from other departments. I understand that is how you did it for midwifery: you got one here, one there and one from—

Dr McCutcheon—We do not have a midwifery component; that must be Flinders. We are looking at a cohort, in the first instance, of 50 for an undergraduate program. In terms of clinical placement, because of our unique relationship with the Royal Adelaide Hospital, we would certainly have no problem in finding clinical placement for those 50 students.

Senator LEES—Flinders?

Prof. Borbasi—What was the question about?

Senator LEES—We were just looking at what might limit you if we were able to encourage government to fund more places.

Prof. Borbasi—In the undergraduate program, I think that, with our dedicated education units, we would not have any problem placing undergraduate students. We do have international postgraduate students coming who are not tied, therefore, to a hospital, and I think there would probably be a limit to postgraduate student placements eventually.

Ms Heartfield—I have one tiny, quick comment that I need to make in response to that, Sally. The DEU model is fine but we cannot afford for that to expand, because where it expands it excludes competition. So it is okay to coexist but expansion is not an option if we—

Senator LEES—So, if they have someone in there two days a week every week—

Ms Heartfield—You cannot get access.

Senator LEES—you cannot put someone in there for a block of four weeks because they are doubling up with—

Ms Heartfield—Exactly.

Prof. Borbasi—With respect to the Royal Adelaide Hospital and the University of Adelaide, that would be another clinical venue that we would not be able to utilise.

CHAIR—If you want more nursing places and you are short only on clinical experience, why don't you argue to reduce the number of overseas students and tell the university to find its funds from somewhere else—train Australian girls to work in Australian hospitals? This is a devil's advocate question.

Ms Heartfield—I am quite happy to answer that from our school's point of view in the sense that the majority of our remuneration from international students is offshore. We are not bringing them here; we are actually bringing their money here.

Ms Gibson—We are bringing a few here.

Ms Heartfield—A few here, yes—the majority.

Ms Gibson—We have a few students from Norway—a very small number who are on a collaborative exchange kind of program. But, as Marie said, most of our teaching is actually offshore. Our staff go and teach offshore.

Prof. Borbasi—I think universities have been depleted in their resources to such an extent that they are now running as businesses, and we have to go out and seek full fee paying students to prop us up in terms of reduced funding. So I know that our international student cohort is extremely important to the budget of our school, and I doubt that we would survive without it.

CHAIR—Is it taking places that otherwise could go to students here?

Prof. Borbasi—No.

Senator LEES—With your midwifery course, could you give us some numbers on that? There is no need to do it now. My last question relates to the two plus two, or the other model we were looking at. We have heard in other places of either an examination—of a sort of ladder that you get off and on—or a system basically where, after, say, 18 months, you can come out as an enrolled nurse, rather than as an attendant. That gets a little more money and helps those people who, while they are studying, have to fund a family. I am wondering whether, as a group, you have looked at that in South Australia. Some of the barriers seem to include some of the unions or the registration people and those who are looking at exactly what it all involves. But how feasible is that, given that we are now seeing, apparently, out there POTS—

CHAIR—People off the street.

Senator LEES—and attendants—they are called different things in different states but I am amazed that there seems to be so many of them out there, and in nursing homes they seem almost to be endemic—and the pressures that that puts on nurses? Have you worked at all in South Australia on some sort of collaborative model where you can start—and I do not know where we start but in schools in New South Wales they can finish year 12 with a certificate. Can I leave that with you?

Ms Gibson—I am aware that there are VET in Schools programs. VET in Schools sometimes do certificate level II preparation and can articulate into certificate level III courses. I know there is a big push in the aged care area to make certificate level III the basic level of qualification for the nurse attendant—multiple named—worker. I am very supportive of that, having worked in that sector and been involved in education in that sector. We recently did some research that looked at some of those areas.

You need to have articulation pathways. The career pathways project that we did for the National Review of Nursing Education clearly talked about articulation between different levels. It is no good burying our heads in the sand and having an ideal notion that a registered nurse is only a registered nurse, and the only way you can produce a registered nurse is by doing this program. We have to be realistic. We have to have articulated career pathways for people who perhaps do not want to be a registered nurse initially but, once they have a certificate level III qualification, then choose to go on to the next level because they have some confidence in their ability or find that they are good at it. They need the opportunity to be able to move on and do that if they so wish. However, it should not be so standardised that it is a very narrow, rigid pathway that everybody has to follow. That is why you have heard about the multiple entry and exit points approach. I think there is certainly some merit in that.

Dr McCutcheon—I would like to respond to the bit about the nurse attendant and the role of the nurse. There are negotiations going on between the union and the nurses board here in South Australia to look at exactly that: the possibility of second year undergraduate nurses being able to enrol and become registered enrolled nurses. They did away with that only a few years or so ago, and they are talking about trying to bring that back again.

CHAIR—Are you talking about the capacity for ENs to go in and do an RN course?

Dr McCutcheon—No. I am talking about the current second year undergraduates, who are now working in the hospitals as nurse assistants, having the ability to be enrolled nurses.

Senator LEES—Does that earn them more per hour?

Dr McCutcheon—Yes. It allows them to have a better salary. There is negotiation going on about that.

Senator WEST—It also allows them to work at a level at which they are better trained. Under the medico-legal aspects of it all, even if they are only an assistant in nursing, if they have done 2½ years of RN training, they are going to be expected to be working to a higher level than an AIN.

Dr McCutcheon—They also know what they are able to do and what they are not able to do. Their role is more clearly defined as an enrolled nurse than as a nurse assistant.

Prof. Borbasi—In the current climate, we would certainly be looking to develop articulation pathways that will bring about change and perhaps ameliorate the current crisis that we have. The School of Nursing is certainly looking to make changes and is aware that we need to start thinking about alternative modes of education and about bringing in the enrolled nurses.

CHAIR—I would like to add to Senator Lees's question: where would this stop? One of the things that interests me is that a lot of nurses go on and get postgraduate training, for which they get almost no financial recognition. Would you see that this articulation of Flinders graduates can actually go to the Royal Adelaide to do postgraduate work?

Dr McCutcheon—Yes.

CHAIR—I thought that would be the case, thank you. The articulation is better academically, but not recognised in financial terms.

Dr McCutcheon—No. Although the recent enterprise bargaining agreement has made some provision for that.

Senator LEES—Is that just here in South Australia?

Dr McCutcheon—I think so, yes.

CHAIR—What provision is that?

Dr McCutcheon—Nurses who have a graduate diploma get some additional remuneration for it. They are also entitled to use the title of 'clinical nurse specialist' if they have a specialty qualification.

Ms Jones—They have to apply for that level, and the individual hospitals set criteria that they believe satisfy the clinical nurse specialist level. Part of those criteria is a graduate diploma.

CHAIR—Let's get real. Certificates are one thing, but how much money do they get?

Dr McCutcheon—I do not know, I am sorry, but we could find out for you.

Ms Jones—I have a document that outlines the difference. It is probably only about $3,000 or $4,000 a year.

Senator LEES—It helps to pay for the course.

Ms Jones—It means that, over the period of three years, it does increase more than it would at the RN level 1.

CHAIR—In other places, people may be qualified to get recognition at a senior level and be eligible for higher pay, but the institution has no vacancies of that sort. Do you know if that is happening here?

Ms Jones—Definitely.

CHAIR—Do you understand that to be a policy of the institutions?

Dr McCutcheon—It is not a policy, but a reality.

Senator WEST—What is the difference?

Ms Gibson—There is an interesting notion in thinking about that. In the universities, while you have a staffing complement and you might be employed at a particular position, they have what is called an internal promotion round every year. So, if you believe you meet the criteria to move from lecturer to senior lecturer, or from senior lecturer to associate professor, you apply. There is an application process. You put in a very detailed application that goes to a committee, they look at it and determine whether you meet the standard for that position. There is the opportunity to be recognised for your skills, abilities and competence even though there may not be a position like there is in the hospital sector. For example, in a hospital you have one clinical nurse consultant and maybe two or three clinical nurse positions, but there may be several other nurses who could be at a level II clinical nurse position—but they cannot be because there are no positions. Even if the numbers were limited, if you said that there were a certain number of people who could be promoted every year, that would be another way of rewarding people in the workplace for performing at a level above which they are paid to perform.

Senator LEES—So you might only have a badge that says you are a clinical whatever and you might not actually be getting any more money.

Ms Heartfield—I was going to say ‘and a payslip’, which is more important for many of them.

Ms Jones—But people would argue in clinical practice that the clinical nurse specialist role has, to a degree, satisfied that need. For example, my clinical setting was intensive care at Royal Adelaide, and 80 per cent of the staff there have a postgraduate qualification in intensive care nursing. They have experience of eight years plus, and they are happy to stay in that environment, despite the increasing pressures of the health sector. However, the reality is that they do not have the opportunity to be in promotional positions and they do not choose to step out of their specialty because they want to stay there. If they did, they would have the opportunity to go to another hospital or another setting outside of their intensive care nursing background. But the clinical nurse specialist role has filled, to a degree, that gap—not just from a financial point of view, but also from the point of view of recognition. A lot of nurses are actually asking for the recognition—

Prof. Borbasi—Absolutely.

Ms Jones—for their prior learning and experience. The financial stuff certainly comes as a bonus but, really, I think you would say that that value for what they have done and for their experience in nursing is as much a reward as the money.

Dr McCutcheon—Yes.

Senator LEES—My final question is along those lines. We have heard that places like New Zealand have nurse practitioners who are, in fact, specialists, like neonatal nurse practitioners. Would that be a further step again?

Ms Heartfield—Yes.

Prof. Borbasi—Absolutely.

Senator WEST—The use of the term 'nurse practitioner' in some states is fairly—

Ms Gibson—Different.

Senator WEST—controversial amongst other health professions, not within the nursing profession.

Senator LEES—To me it seems to indicate an ability or independence that moves you further away from needing medical support.

Prof. Borbasi—Yes, absolutely.

Dr McCutcheon—I think we have to be very careful that we do not create a bigger and bigger hierarchy of nurses. We have already gone down the path of having a career structure where we had RNs, CNs, CNCs, nurse managers and what have you. The nurse practitioner concept, whilst it is valuable, for a lot of people is another tier. I am not saying that it is not good, but I do not think the debate has been wide enough or deep enough to see where these people are going to fit. In rural areas, there seems to be a very clearly defined role for them. In a tertiary facility, like an acute care hospital, a lot of people are still not sure about that.

Prof. Borbasi—I think the nurse practitioner role is highly important. Nurses have discussed, debated and thought about it enormously. It is a way, as you said, for expert nurses who have been in the system for a long time to be recognised for their expertise, to develop autonomy in practice and to have accountability and responsibility at a level that nurses have not had before. I believe that it is a role that needs to be pushed along quickly.

Ms Heartfield—In regard to nurse practitioner education—and, again, I am not going to step into the debate about what it actually is—we have a Masters of Specialist Practice that is designed to prepare nurse practitioners. We see that as a niche market. We have had approximately 20 to 25 students over the last couple of years. That market is growing. We are putting that program online, like most of our programs, because there is interest nationally in doing that—but it is a niche role, as Sally said.

Senator WEST—Did I understand you correctly, Dr McCutcheon? Did you lead me to believe after your last comments that there was already an adequate career path for nurses?

Dr McCutcheon—No. I would not say that it is adequate. I think we went down the role of the career structure. Everybody embraced it. Most of the people around here would say it has not worked terribly well. What we have now is a work force of nurses that are incredibly well educated who do go on to do more and more postgraduate work and seem to be continually at a level where they do not see promotional positions for them. I do not know how we fix that other than trying to get our nurses to see that to move laterally can be just as rewarding as moving up, particularly in terms of satisfaction in their job. I do not know that we have got a terribly good career pathway.

Senator WEST—I am wondering how many PhD—doctors who are nurses, and professors who are nurses—you actually see at the bedside, giving clinical care. I would suggest not too many. With all due respects to you, you are all in academia or in administration.

Prof. Borbasi—I would like to respond to that. We have a large PhD school. Increasingly there are clinicians coming in to do PhD studies and going out and working at very high levels as consultants in clinical areas and within wards and they have the expectation therefore that, postdoctorally, they will go on and do research in their clinical areas. That is becoming more and more evident as clinicians are coming in to do PhDs.

Senator WEST—That will be very interesting. When you say, 'Doctor,' which one answers?

Prof. Borbasi—They are very keen in the nurse practitioner role.

Senator WEST—The other doctors are not.

Prof. Borbasi—And clinical chairs, of course.

Senator WEST—I come from New South Wales and I am also four-year trained in a hospital. So a three-year undergraduate sounds very nice.

Ms Jones—I would like to make a comment. At Adelaide University, in addition to the PhD, we also have the Doctor of Nursing, which is a professional degree. I am a current student of that. I am just about to finish and so is my colleague, Judy. It is designed for clinical leadership. We still do a research component of the degree and hand in our thesis at the end of it that has demonstrated that we can produce a substantial part of research that impacts on nursing. But it also has the ability to broaden our minds into health generally, not just at a local level or even a national level, but a global level and it addresses more of those clinical leadership management administrative things.

I just wanted to make a comment about what you said: that we are all standing up here as academics and managers. That is true. I do believe, as a new academic, that unfortunately what happens is you get good clinical nurses who have the ability to progress and do very good work at the bedside. Those people are targeted for project positions within the DHS or various other organisations. It is a problem because those of us who like clinical nursing want to stay in clinical nursing, but we feel that we can do more for nursing by being in these positions. I guess

one reason I believe so strongly in our department is because it has such a clinical focus and because we are still part of the hospital culture.

Senator WEST—Professor Borbasi, in your submission you talked about the renegotiation of health care needs and the boundaries between the various health practitioners and basically a complete throwing up in the air of the delivery of health care and a bit of scramble to see who can get what out of it, or claim some territory.

Prof. Borbasi—I think the boundaries are blurring between what nurses do and what junior doctors do. They have always been blurred but they are becoming increasingly so because of the technological developments, the acuity of the patient in the hospital and the fast throughput within the hospital.

The health care system has changed enormously in recent times. Because registered nurses are not out there in the numbers that we would like them to be, we are getting these so-called PCAs, or patient care attendants, coming in. Even the role of the registered nurse and the PCA is now becoming blurred to some extent so that PCAs are taking on nursing roles. Some debate and discussion needs to take place fairly shortly about the blurring of these boundaries and where people's responsibilities lie.

Senator WEST—Is it that the issue is not one of the numbers that are actually going into undergraduate courses but the numbers that we are losing, and how we stop that? Is that the biggest problem: how do we stop that and what do we do to change it?

Prof. Borbasi—Do you mean the numbers at the other end in the work force, once they are registered?

Senator WEST—Yes.

Prof. Borbasi—That is an issue.

Senator WEST—Not the attrition rate in universities, but the attrition rate in the work force.

Prof. Borbasi—Yes.

Senator WEST—I think it has always been fairly high.

Prof. Borbasi—Absolutely. It is the retention in the workplace. It is not recruitment that is an issue; it is the retention.

Dr McCutcheon—We have peaks and troughs. If you look back, we continually have peaks and troughs but what tends to happen is that long-term work force planning does not happen in terms of having a vision and sticking with it—it happens because of bandaiding. When we have a peak of nurses, they pull back. It is a case of saying, 'We don't need to have all these students going through undergraduate programs because we've got a surplus of nurses.' Then, five years go by and we have a trough again and they think, 'Now we've got to push more into courses.' We need to talk to the policy people and say, 'We know we have an ageing population, we know

that these diseases are prevalent, we know that the incidence of this is high. We need to do our planning in light of all these things and not just because this is how much money DEETYA is willing to give us.' Planning has to be with a bigger picture in mind, not just with a narrow focus.

Senator WEST—Is this trough or this shortage actually a different type from the ones we have previously experienced? We are seeing the population demographic move up, the baby boomer bulge is moving into the rather critical areas of retirement and the ageing process. What should we be doing to address that over the next 10 years?

Prof. Borbasi—Young women have so many more choices nowadays. Predominantly, it has been women who went into nursing. They did not see it as a high status professional occupation, so there are those issues involved. Generation Xers do not have the same values or attitudes to work that we, or I, may have had as a baby boomer. It is different, we are living in a different world and there are different issues that need to be considered.

Senator KNOWLES—It is not just the ageing population, is it? It is the expectation that we can now be cured of everything—with technology being what it is and medicines being what they are—so the role of the nurse is becoming even more critical.

Dr McCutcheon—People are living longer and then getting sicker towards the end.

Prof. Borbasi—People are not allowed to die.

Senator KNOWLES—And they still expect to live.

Prof. Borbasi—Absolutely.

Dr McCutcheon—There is a cost associated with the success of our doctors and nurses.

Prof. Borbasi—And there is the lack of funding.

Senator WEST—I would like to know more about the two-two, the three-one and the four-year program. I am concerned about the ability of nurses to finish in three years. As an old four-year trained nurse, I did not ever think that three years was long enough anyway. I was still pretty useless in my first year as an RN, I have to say. What are your plans and how do you think it should work?

Ms Heartfield—The school as such does not have one plan in place to implement that. We are talking about a number of plans. Terri and I have been involved in the review of competency standards for enrolled nurses that took place through the Australian Nursing Council last year. We speak with a liberal mind in terms of the potential that is there to, as Senator Meg Lees said, articulate nursing through. So what that fourth year might look like is open to discussion in regard to what precedes it. Obviously, there is the issue about increased clinical competency, and what that might look like needs to be negotiated with our industry partners. There is also an awareness of being able to create honours pathways, where nurses get an additional opportunity to think about the clinical areas of practice that they might wish to investigate further through a small amount of project work. That is something that could be accommodated within that fourth

year as well. As we put in our submission, the models for an internship, or extended studies, which would incorporate clinical work or an articulation with enrolled nurse programs, are all options that are open to development.

Ms Gibson—I would like to make a comment about the notion of an intern year. As you are probably well aware, currently in our state and I think in most states, funding is given to the hospitals for new nursing graduates to cover their graduate program. I am not sure how effectively that funding gets through to the right place—I suppose that is one question that might be asked of our colleagues in the hospital sector. However, I think there is room to be more innovative with those programs, to help the new graduate make the transition into the work force more effectively and develop the clinical competencies that are required. I think there could be some work in that area. Suggestions that have been put forward about that include having the three-year undergraduate degree and then students would have preliminary registration and be paid at a particular level while they are undertaking that year while being very well supported. The issue of mentoring and supporting people in the workplace is very important. There are some opportunities to come up with new ways of doing it and perhaps meeting the needs of the clinical environment more effectively.

Dr Neill—I want to say something that is a little off the track—I wanted to bring it up earlier—about our graduate entry students in a highly successful program at Flinders University. They already have a degree in another discipline and they come to us for a two-year program. The evidence so far indicates that those students, as graduates, fit into the work force extremely well. It is a way of reducing the amount of time that students spend in their training for nursing. The unfortunate thing about it is that we do not have many funded places for it and we actually take a few places from here and there to make up our numbers. If that program had a better allocation of DST places, it could improve the situation a little bit in the short term. But, like our undergraduate program, we are consistently overenrolled in that program without additional funding to support it.

Senator WEST—Adelaide University, can I ask you what clinical component you would be expecting to have? What percentage would be clinical for your proposed undergraduate course?

Dr McCutcheon—In the first year, we envisage two days a week for 42 weeks a year; in the second year, three days a week for 42 weeks; and in the third year, there would be blocks of time—approximately six weeks at a time—looking at at least five of those. What we are looking at is a 52-week year with four or five weeks annual leave, and the rest of the time the undergraduates would be either at university or working in the hospital. Some time would also be spent in a clinical placement, but the hospital is looking at being able to provide scholarships—or some other creative way of allowing these students to get remuneration for the time they are in the hospital.

Senator WEST—It sounds awfully close to the old apprenticeship with the block—

Dr McCutcheon—No, it is absolutely not that. We are looking at having students working more than just three, four or five hours a day. We are looking at making better use of them.

Miss Magarey—You would not call the MBBS program purely an apprenticeship program, and that has a similar type of year that extends right across the semesters, not just limited to the two semesters per year.

CHAIR—Some people would, Miss Magarey. They have been abusing me about it for 25 years!

Ms Heartfield—Further to my earlier comments, can I say that that model has probably been planned without the current collaboration that Flinders and ourselves have about clinical placements. If the Royal Adelaide Hospital was to be removed, that would significantly reduce our opportunities for clinical placement. It is a substantial organisation that is a core provider of clinical placement opportunities.

Dr McCutcheon—The Royal Adelaide Hospital have indicated that they would not be reducing the amount of clinical placements they have available for the other universities. This is in the planning process.

Prof. Borbasi—Can I reiterate that clinical placement is not an issue for us. Our students go out to our dedicated education units and we are quite happy with the end product. What is lacking is the funding for the clinical placement experience. I do not believe that the majority of faculty would agree with increasing the time on clinical placements as our students are at a satisfactory level when they graduate. Many of the issues about retention are in the workplace.

Senator WEST—My last question arises from evidence given in other states. Are you being charged by these institutions for the privilege of having clinical placements or not?

Prof. Borbasi—Not yet.

Ms Heartfield—It is being mooted.

Prof. Borbasi—Do we? Can I withdraw that statement?

Dr Neill—The dedicated education model does not charge us directly but we pay for backfill while the clinicians are doing staff development with us. We pay backfill for a registered nurse to be upgraded to a level 2 clinical nurse position to be acting as a DEU liaison nurse during the time that we have students in those clinical areas. So, in fact, we do pay and we also pay for clinical placements of students in rural and remote areas—we pay preceptor rates; those sorts of things.

Senator LEES—How do you get people out there in remote areas for two days a week?

Dr Neill—We do not run a rural and remote model in that way. The University of South Australia has a different configuration and an external program, but we actually have to send our students out in a block because of the way the university program is configured. They go out for six weeks or 16 weeks.

Senator LEES—Does that still include Alice?

Dr Neill—It does still include Central Australia, that is correct. It has been really quite successful in retaining students and attracting them back to those areas after graduation.

Ms Gibson—Similar to Flinders, we do pay for some of our placements, but they are usually in some of the more rural or remote areas. Occasionally, because our students do have some choice about where they go for their final practicum placement, we may have a student who is placed interstate and there is a payment that accompanies that. We also have students who come from interstate who have placements in South Australia. There has been a lot of talk about paying for the clinical placements, but what we do have to do is pay for extra clinical facilitators. We have different ratios in first, second and third year, which means that, when we get a larger complement of staff than we currently have as part of our standard academic staff, we will bring on up to 15 clinical placement facilitators. These are registered nurses who have some educational background and experience with very good clinical skills, and we employ them to be out there to assist with the facilitation of student placements. So that is a significant cost.

Senator TCHEN—Dr McCutcheon, you suggested that a 'boutique' program should be offered to talented school leavers. Leaving aside the fact that you actually do not take school leavers, what do you mean by 'boutique' programs?

Dr McCutcheon—I have actually defined that here in writing: a small program that produces individual and very high-class nurses. We are looking at taking school leavers who have got very high TER scores and providing them with a fairly intensive three-year program which, at the end of it, will come out with graduate nurses who are probably, to some degree, more capable than the average nurse who leaves the program. That is what I mean by a 'boutique' program.

Senator TCHEN—It seems to me that in nursing you do not necessarily require people who know how to cut up people and put them together again but know how to empathise with patients. You might be creating the type of nurse who actually does not deal with patients.

Dr McCutcheon—No, I disagree. I think you can have very intelligent individuals coming into nursing who can be fast-tracked but who still—

Senator TCHEN—I am sure all nurses are very intelligent people anyway.

Dr McCutcheon—epitomise the caring that is required to look after people. I do not think highly intelligent people necessarily will go into research or academia; a lot of them are more than satisfied to be clinicians at the bedside.

Senator TCHEN—You also talked about your proposed program to assign undergraduate students to a clinical practice two days a week, 52 weeks a year, less annual leave. But the university year is only 26 weeks. What do they do with the rest of the time? Do they work for just two days week and the rest of the time do not do anything?

Dr McCutcheon—The rest of the time there is the potential for the hospital to employ them and remunerate them at an appropriate level.

Senator TCHEN—It just sounds like the old apprenticeship system. I will not ask the other ladies to comment, because I know you disagree with that; you have already indicated that. The University of South Australia: you argue that nursing places should be HECS free. That part is understandable. A lot of people have suggested that to us already. But you also say that it should be supported by state governments. I love that bit. Can you elaborate on that?

Ms Gibson—Let me clarify that, because I think I was responding to the point that Senator Knowles made about—

Senator TCHEN—No, it is actually in your written submission.

Ms Gibson—Sorry; let me have a look at the submission. Can you direct me to the page, please?

Senator TCHEN—It is on page 3, in the fourth paragraph, where you say that it should be achieved 'by all nursing and midwifery places being HECS free and supported by state governments'. Can you elaborate on the second part?

Ms Gibson—What is being referred to in that submission is probably what has already come about, which I did not get an opportunity to say in my earlier response—that is, the state government has this year given us $125,000 to bring some extra places in. So I suppose we were not necessarily saying we would take away the role of the Commonwealth in funding; it would not be our jurisdiction to make that statement. However, apropos my earlier comment about Commonwealth and state relations and some discussions around funding, those kinds of initiatives are really important initiatives that will actually help meet the immediate needs that were talked about, in terms of a closer interface between the needs in the local area and how they can be best facilitated beyond what the standard funding is.

Senator TCHEN—Professor Borbasi, you mentioned in your oral submission earlier that the number of HECS funded places has been halved over a period of time. Over what period?

Prof. Borbasi—Halved over the last five years.

Senator TCHEN—Is that at all universities, or just at Flinders?

Prof. Borbasi—In all university bachelor of nursing programs.

Senator TCHEN—This is the first time I personally have heard that comment from people making submissions. I was not aware that in fact it had actually been halved.

Prof. Borbasi—This is a statement from the dean. I will check it with her.

Senator TCHEN—Can you give us the reference for that?

Prof. Borbasi—No; it is just a statement that she has written. So you can reference it to her.

Senator TCHEN—In that case, we probably need to do some research on that. You argue that professional boundaries between nurses, say, and medical officers need to be redefined, and also the boundary between nursing and other health professions and occupations needs to be redefined.

Prof. Borbasi—Yes.

Senator TCHEN—Can you elaborate on that idea? The question leading on from that is whether that need to redefine has been taken into nursing education as well as nursing practice. Perhaps the other ladies may care to comment as well, after you.

Prof. Borbasi—We are looking at a nurse who is now graduating and going on to postgraduate studies and has enormous knowledge and skills—far more than nurses have had in the past—and yet the system in the workplace has not moved or changed to accommodate highly educated nurses. There are nurses out there—and they are particularly expert nurses who aspire to nurse practitioner roles, for example—who do have the knowledge and skills, and that means that they can provide knowledge and skills that you might think traditionally belong to medicine. And yet medicine is also moving its boundaries, because of technological innovations and scientific developments. So the whole thing is shifting.

Medicine has traditionally discarded roles at the bottom of its hierarchy to nurses, and nurses have taken them up, and they are doing that. Take the nurse practitioner role in New South Wales, in the emergency department: 50 per cent—and do not quote me on that figure—or a large percentage of patients who come to emergency departments, for example, should really go to a GP and they could easily be seen by a highly experienced, knowledgable nurse practitioner who has emergency department expertise. He or she could clear the backlog. Certainly in my experience there are nurse practitioners out there who could take on roles that doctors do not have time to perform, where there are no doctors to perform them, and nurses are doing this in rural and remote areas. They are performing traditional medical interventions and consultations. Yet that is not recognised, and I think it is time that we did recognise it.

Dr McCutcheon—We need to be careful that we do not take on roles discarded by the medical profession. We need to develop nursing practice and, if we have nurse practitioners, it should be with nursing roles and not discarded medical roles.

Prof. Borbasi—I would agree with you there, but there needs to be discussion and debate about the sorts of interventions they are making.

Senator TCHEN—Does anyone else wish to comment on that? No?

Ms Gibson—We will stay out of that one.

Senator TCHEN—It is just that when you were discussing that it occurred to me that some university medical faculties, notably Newcastle and Flinders, see the doctor’s role as actually moving down to encompass some of the traditional nursing roles.

Prof. Borbasi—Yes.

Ms Heartfield—Yes.

Senator TCHEN—With nursing training, one of the issues which is constantly brought to us is the implication that we need to increase recruitment and attract young people into nursing streams. It seems to me that, as the population ages, we probably should be looking at attracting mature aged professionals to serve that ageing population—and also perhaps some of the people approaching the aged category.

Prof. Borbasi—I think that already happens.

Dr McCutcheon—Absolutely.

Prof. Borbasi—A large percentage of our students are mature aged students.

Senator TCHEN—The other question related to that is that there is a lot of talk about the attrition rate in nursing after graduation—nurses do not stay in the profession. Because nursing education is developing and becoming a more broad based education, are people actually using nursing education as a way of transferring to other professions?

Dr McCutcheon—Most definitely.

Prof. Borbasi—Because of dissatisfaction in the workplace, some graduates will use elsewhere the skills that they have learnt in nursing.

Senator TCHEN—No. I mean that, because they are highly skilled, they have more opportunities to opt out of nursing.

Prof. Borbasi—Absolutely, yes.

CHAIR—Perhaps I can give you my questions and, if there is anything further, perhaps Dr Neill can take the answers—because we are out of time.

Dr Neill—Yes, absolutely.

Prof. Borbasi—Thank you, and thank you for this opportunity.

CHAIR—Can you on notice provide for me how many of your undergraduate students are 18-year-olds and how many are mature aged—and any breakdown of them? As I understand it, the largest block of them would be coming from school.

Ms Heartfield—I think we would be the other way around, but I will provide statistics.

CHAIR—Can you tell us what category of ‘other’ they are? Are they mature age at 21 or 25, or at 60—to take into account Senator Tchen’s concerns for keeping up with the ageing population? One thing I am interested in, and perhaps you can answer this briefly, is brand loyalty to a place. If your nurses are trained at the Royal Adelaide and come out of the Royal Adelaide and do their clinical experience there, they have a culture of that place and so they say,

'I'm an RA nurse' or 'I'm a St Vinnie's nurse' or 'I'm an RPA or a Mater nurse'. There is a brand loyalty that in the past was attached to nurses. I have not yet found it attached to 'I'm a Flinders University nurse'. Maybe I am missing it. Please comment on clinical placements that attach to the one place so that the culture of that place is picked up by the nursing students.

Dr Neill—Our students are actually placed in a variety of venues, and so they would visit a number of major public hospitals in the state. They would also go to small private hospitals and rural hospitals, some of them—

CHAIR—Is it a plus or a minus? Would it be better if they did it all in one place?

Dr Neill—I think it is a plus. I do not think there is an identification with one particular area, although it might be true to say that, in the students' last semester of practicum, they often use those placements as a way of looking for an environment that they feel comfortable with or would like to work in as graduates. Certainly from my own experience as a principal academic in one of the DEUs that we were talking about, quite a number of the students that I had as third-year students last year have been re-employed in that area.

CHAIR—Which one is that?

Dr Neill—It is in the Flinders Medical Centre.

Dr McCutcheon—We do not have a undergraduate program, so I cannot say. However I think that in the model that Notre Dame in Fremantle are using, where they have Notre Dame nurses working at Fremantle Hospital, they seem to be having exactly that brand name thing happening, where the nurses see themselves as being Fremantle Notre Dame nurses, or whatever. So there seems to be some value in that; other people would say not. There are arguments on both sides.

Ms Heartfield—I think we would have to say that diversity is good—to again maintain our theme for the morning. Just to make the point about brand loyalty with regard to graduate education, there is a strong trend in brand loyalty for our graduates to come back to us as a university to do their graduate studies, and obviously we encourage that.

CHAIR—You were talking about—I forgot exactly what the word was—hiring clinical preceptors or clinical—

Ms Gibson—Clinical facilitators.

CHAIR—I have 'preceptors' and 'supervisors', but I had forgotten 'facilitators'. Where do you hire them from?

Ms Gibson—We have a pool of registered nurses. That is their basic level qualification. We usually try to have them as registered nurses with at least a bachelor degree as well.

CHAIR—Are they hired through agencies?

Ms Heartfield—Predominantly they are free-ranging individuals who might choose to take leave from their clinical place of employment to undertake this work with us, because they see it as a development opportunity. Sometimes they are people who have casual employment. Some of them do come through agencies. They come from a wide range of areas, but they are employed usually in clinical roles.

CHAIR—So you would actually ring up the Royal Adelaide and say, 'Clinical facilitator X, we need you for a block of education'?

Ms Heartfield—We have a database that we renew through—

CHAIR—You just do it by the MO; you do not ring them up?

Ms Heartfield—No.

CHAIR—I will try and catch up with the new technology. So you actually pull them out of their clinical situation—or sorry, they opt to come out of their clinical situation to do this teaching?

Ms Gibson—All of those models; all of the above. We have actually negotiated arrangements sometimes with an individual, sometimes with an organisation. As Terri said earlier, we know we might be sending students to a particular organisation, and that organisation may have staff members who have done this work in the past for us and choose to be released to take on this responsibility.

CHAIR—How much do you pay them an hour?

Ms Gibson—It is $26 or $27 an hour. That is my recollection. But I can get you the exact figure when we provide the other information.

CHAIR—If you use a clinical facilitator from an agency, how much do you pay?

Ms Heartfield—We would need to get that information to you.

CHAIR—Can anybody tell me how much more the agency nurses cost, compared with a non-agency nurse?

Ms Jones—Those nurses get about $70 an hour: if they work after hours and in specialty areas, they can get up to that amount. It depends on which agency they work through. It is significantly more, and a lot of nurses are leaving practice in order to be agency nurses for that reason.

CHAIR—Are you aware of the agency nurses in Victoria who were charging up to $200 to $250 an hour, 55 per cent of which remained with the agency—

Ms Heartfield—Yes.

Ms Gibson—Yes.

Ms Jones—Yes.

Dr McCutcheon—Yes.

CHAIR—which practice is now banned by the Victorian government for employment in the public hospitals, assessed to save $20 million? Do you have any idea at what cost—how many nurses are being employed here as agency nurses?

Dr McCutcheon—No.

Ms Gibson—I have no idea.

CHAIR—I will chase that up in another quarter, thank you very much. Perhaps you are not the people to ask this of, but we have a concern about the cancelling of insurance for midwives. Do you have any information that you can offer the committee; or is it called 'please ask somebody else'?

Ms Heartfield—Just speaking from the University of South Australia's perspective, I can only say that we are in exactly the same situation: we have our insurance in place at the moment but we know that it is due to expire very soon, and the terms under which it will be renewed are being negotiated.

CHAIR—'We have our insurance': what does that mean? The University of South Australia has insurance, or you, the nursing lot?

Ms Heartfield—The University of South Australia has insurance cover for students to be out in clinical placement. Interestingly, within a division of health sciences, nurses are seen as being particularly interventionist within a number of health science practices.

CHAIR—So at the moment your nurse students are covered by a University of South Australia insurance policy—which would cover medical students?

Ms Heartfield—We do not have medical students—but it covers all of our health sciences: physio, OT and all of the health sciences within our division are covered under a similar insurance scheme.

CHAIR—Do you know who that insurance policy is with?

Ms Heartfield—I would need more information—although you might know.

Ms Gibson—The university does have some forms of insurance with AON, but we would have to check and get back to you about whether they also cover that aspect of insurance. We could give you that information, though.

CHAIR—That would be very helpful.

Dr McCutcheon—At Adelaide University we do not have midwives, but all our postgraduate students are covered by the university's indemnity insurance. I could not tell you who that insurer is but I can find out for you.

CHAIR—That would be helpful—and also if you get any suggestion that the insurance policy covering the Adelaide is also looking at withdrawing its coverage of students.

Dr McCutcheon—No; it has just been renewed.

CHAIR—And you have medical students too.

Dr McCutcheon—Medical students as well.

Dr Neill—My understanding is that the students union actually has the insurance policy for our nursing students and other students in the university, for clinical placement. It is the midwifery students that we are having trouble getting indemnity insurance for, for them to do their places. I do not know the exact situation, but I can check that up.

CHAIR—Could you please check that? You are telling us that nursing students at Flinders are covered by an insurance policy through the student union?

Dr Neill—That is my understanding, but I can check that.

CHAIR—If you could provide us with some information on that, that would be very helpful. We have 5,000 questions and we have minus 10 minutes. It has been extremely useful. If there is anything further that you desperately needed to say and did not get onto the record, we have your submission and your contribution, but please feel free to provide us with any other information—in dot point form, not a thesis. I know you are all frantically busy but I presume that, if we have further questions we would like to ask of you, we can contact you. A very interesting and sexy start to the day. Thank you very much.

[10.56 a.m.]

BLOTT, Mrs Susan Frances, Member, Australian Nursing Federation

BONNER, Mr Robert, Senior Industrial Officer (SA), Australian Nursing Federation

ILIFFE, Ms Jill, National Secretary, Australian Nursing Federation

PARKES, Ms Robyn Janette, Member, Australian Nursing Federation

THOMAS, Ms Lee, State Secretary, Australian Nursing Federation (SA Branch)

ZUCH, Mrs Antonia Wilhelmina, Member, Australian Nursing Federation

CHAIR—I welcome representatives from the Australian Nursing Federation, including those from the South Australian branch. I would particularly like to acknowledge representatives from the ANF for assisting the committee's scheduling of witnesses by making themselves available today. The committee prefers all evidence to be heard in public, but if you wish to give any of your evidence in camera you may ask to do so and we will give consideration to your request. I need to remind you that evidence given to a committee is covered by parliamentary privilege and that intentionally giving false or misleading evidence to the committee could constitute a contempt. The committee has before it your submission, No. 962. Do you wish to make any alterations to this submission?

Ms Iliffe—No, thank you.

CHAIR—I invite you to make an opening statement and then you can field questions.

Ms Iliffe—The way that we would like to structure our evidence is for each of us to give a brief opening statement on our different perspectives, and then that will leave as much time as possible for questions. I want to inform senators that one of our witnesses, Antonia, has a hearing problem. You may need to make a hand signal when you are asking her a question so that she knows which of you is asking a question.

CHAIR—That is very useful, thank you. Mrs Zuch, do you need to lip-read?

Mrs Zuch—No. As long as the person just lifts their finger, I know who is talking. It is more the distortion of sound. If Senator Tchen is talking, the sound comes from Senator Lees. Then I will look at Senator Lees, and she is going to think I have lost the plot.

CHAIR—Thank you, Mrs Zuch. We will take instructions if we are not doing that well. Thank you for that advice, Ms Iliffe.

Ms Iliffe—The federation feels that at a national level—and I stress a national level—nursing has been quite neglected. This has resulted in an undersupply-oversupply swing, and ad hoc

crisis responses from the state and territory governments which are very cost inefficient. What ANF hopes will come out of this inquiry is a considered and long-term practical national strategy that can be supported by the nursing profession.

We feel that there are two main reasons why we have a current crisis in our nursing work force, and both need to be addressed for a long-term solution. The first problem is recruitment. We need to know what our national nursing work force needs are at an undergraduate, post-graduate and enrolled nurse level. We need to set some targets and then we need to recruit to those targets, and we need to look at the work place issues. We also need to look at why it is difficult to retain nurses in the work place, and that is the second problem. We think that there are a number of reasons for this. The main ones are staffing levels, which means that there is decreased job satisfaction and an increased concern about professional accountability. Some of our witnesses will address that more fully.

The aged care sector has specific issues. The salary gap between nurses working in the aged care sector and those working in other sectors is one of the prime reasons why it is hard for the aged care sector to recruit. The most common additional concern for our nurses working in rural and remote areas is access to ongoing education. The ageing of the nursing work force is an issue. Something that needs to be factored into the equation is that 30 per cent of our nursing work force is going to be contemplating retirement within the next 10 to 15 years. We need to replace not only the numbers but also the skill levels and the expertise.

But it is not all doom and gloom. The ANF is very positive that there are strategies and answers to the questions and the problems. I think the evidence is that, when current enrolments are addressed, when marketing is done, you get a response. We have seen that with the response to the enrolment in universities this year, where almost all of the universities have been oversubscribed. A lot of nurses are also able to return to the work force if they are given some encouragement to do so, not just with re-entry and refresher programs but with improved conditions in the workplace. I think the recent experience in Victoria has shown that, if you improve the workplace, nurses will come back into the work force.

In summary, we are looking for some national planning, some recruitment targets, improvement in the workplace so that we can retain our nurses, attention to salaries in the aged care sector and a voice for nursing at the Commonwealth level. At the moment, the very fact that there is nobody who speaks for nursing, who coordinates all the activities going on at a Commonwealth government level that impact on nursing, is a big disadvantage to the nursing profession. I would now like to ask Lee Thomas, who is the Secretary of the South Australian branch, to make some opening comments.

Ms Thomas—I am delighted to be here today and our delegation is delighted to be able to make submissions to you. We all have an area of specialty. I am going to talk about the nursing shortage, particularly in this state. I am sure you have heard a lot of stories about it as you have been around the country. On the current figures available here in South Australia, it is estimated that we are approximately between 500 and 700 registered nurses short of our requirement. The South Australian Nursing Labour Force Planning Committee, of which the Australian Nursing Federation is a key player, has examined the need in number terms for the future and has recommended strategies that would enable us to fulfil the requirements in relation to those

numbers. We have been looking at current attrition rates, undergraduate nursing places, the product from the university and the requirements for this state.

The recommendations from that committee include the need to urgently and massively increase the number of registered nurse graduates from the current 350 to 400 students to around 1,000 to 1,350 per year. It was necessary for us to increase those numbers immediately beginning the academic year 2002—this year. If that was not done, by 2004 South Australia could expect its requirement for registered nurses to be around 15,000 and we would have approximately 13,500. So we would be around 1,500 short by 2004. In the academic year 2002, South Australia received an extra 40 state funded places. Whilst it was well short of the about 800 extra that we needed, it certainly saw some movement there. It was recognised by the South Australian Nursing Labour Force Planning Committee that, if the intakes of undergraduate students were not increased, the present and forecast undersupply of graduates and the associated inability to maintain the required registered nurse work force would have a significant effect on the quality and capacity to maintain service delivery in this state over the next few years.

There are also other recommendations, and they generally refer to increasing the infrastructure requirements for universities, in line with increased intakes of undergraduate students, and associated issues. The final recommendation deals with the short-term issue of undersupply and examines issues such as refresher and re-entry courses for nurses who, for a variety of reasons, have chosen to leave the profession. It also looks at the employment of third year undergraduate students and the better articulation of the enrolled nurse and registered nurse transition processes through nursing training.

Whilst that is the overall perspective, there are differences across and between metropolitan and rural areas. Aged care, for example, is worse off in registered nurse or in staffing terms than perhaps the public or private acute sectors. That in the main is due to poorer wages and conditions of employment. Whilst the ANF continue to strive for uniformity in wages and conditions in this state—and we have gone some way to addressing those issues—it will take some time for employers in this sector to realise that there is a crisis, before they accept that wages comparable with the public sector are important.

That is in relation to registered nurses. Of course, we have enrolled nurses here in this state. Currently we are producing about 239 enrolled nurses a year. This is very new data. The enrolled nurse numbers have only just been reviewed in the last month. In addition to the 239, there are around 25 refresher and re-entry enrolled nurses, which is a total of about 264 per year. We need between 347 and 468 per year to fulfil the normal turnover in the profession. Therefore, we are recommending an increase in structured intakes of the EN program, but the increases must be over and above those numbers in order to fulfil the short-term problems that we have in registered nurse numbers. That is a brief overview of the shortage in this state.

What the South Australian labour force committee has recommended—and certainly we, as part of that, have continued to strive for—is urgent action to increase the number of funded places in undergraduate nursing degree courses. It recommends a commitment to a national and state work force planning committee that can address regularly the issues plaguing the profession, taking into account the ageing work force and areas such as midwifery and mental health—specialty areas which also have shortage problems. There needs to be an avenue to

address cross-sector differences and metropolitan and rural differences as well. That is all I have to say. Thank you.

CHAIR—I was just about to give you the 30-second wind-up call. I wonder if we could either zap fast, or could you give your point punchily. I do not want to say, ‘Don’t come with your prepared piece,’ but if you can make it pungent, we can take more questions.

Mr Bonner—I will abbreviate the presentation. I am dealing with staffing levels, skill mix issues and the use of agency staff within our hospital system. Nurses from all sectors are raising concerns about staffing levels and skill mix and, in particular, the effect they are having on their capacity to provide for their patients or clients what they think are reasonable and safe levels of care. This is a key issue that has arisen in a number of surveys, including some surveys that we ran in 1999. It is leading to nurses actually reducing their hours of work as a way of coping with what is going on—in terms of the stress levels of the work environment—or leaving the profession altogether. I can give you some indication of what the shortfalls are, given some of the tools that are available to us.

In the acute public hospital system in South Australia, we have a staffing system that is based on a clinical computerised information system called Excelcare. Excelcare shows, in almost all hospital environments, that staffing levels rarely, if ever, match the level that has been clinically determined as being required by the dependency systems of the hospitals. For example, at the Queen Elizabeth Hospital in the western suburbs in Adelaide, between January and December 1998, the average difference was 22.5 per cent between the numbers of nurses required by the clinical system and the numbers actually provided on the day. In the period January to December 2001, the difference had grown to 26.25 per cent. So what we have is an understaffing problem that has grown worse in that particular environment.

In the southern suburbs last year, in the Flinders Medical Centre, we had industrial action taken by nurses that closed up to 40 beds for a period of up to three months due to, again, an incapacity or an unwillingness to staff to the Excelcare demand. In the northern suburbs, at the Lyell McEwin Hospital last year, between January and September 2001, the difference between Excelcare demand and actual staffing was nearly 25 per cent. It is a chronic problem in our public hospital system. The system seems to be breaking down because the case mix system of funding provided to the hospitals bears no relationship to the clinical information or the staffing requirements of the organisation. So we have hospitals trying to staff according to clinical demand but at the same time being constrained by a funding system that does not relate to that.

Of course, the shortage of registered nurses who wish to participate in the labour market means that hospitals are finding it difficult to staff their rosters just because of the availability of nurses who wish to work. But it has to be said that the hospitals have shown great reluctance to enter into schemes that will actually drive nurses back into the work force through, for example, good support for study and conference leave, assistance with meeting course fees and so on that have all been suggested over a couple of years now but have largely not been taken up by the hospitals, again due to costs.

Turning to agency staff, one of the key things going on at the moment, and over the last couple of years in particular, is that nurses have been driven out of the permanent or part-time work force into casual or agency employment. We believe that they are largely doing so because

their working lives in permanent employment have become intolerable due to issues such as workloads, inflexible practices, dissatisfaction with their role and many other issues. Hospitals and aged care facilities have become increasingly reliant on agencies to meet their day-to-day staffing issues. It is no longer the case that agency staff are just providing top-up staff to meet the extreme fluctuations due to increases in demand.

Again, using QEH as a reference point—and it is almost unfair to do so, but they do provide regular published statistics which help deal with the issues—in 2000-01 for the period July to September, the agency staff comprised 5.6 per cent of the nursing work force at the hospital. By 2001-02 in the same period, the situation had grown to 15 per cent of the total work force at the Queen Elizabeth Hospital being made up of agency staff. The position at QEH, it has to be acknowledged, is exaggerated, because the hospital has had some question marks over its whole future, which makes it more difficult for that organisation to compete for nursing staff. But dealing with a smaller health service, the Lyell McEwin Health Service, they have experienced a growth of three per cent of their staff from the agencies to five per cent over that same year-to-year basis, an almost doubling of the reliance on agency staff. Clearly, there are problems associated with that in terms of the quality of care issues that flow.

Finally, dealing with the issues in aged care, we have an almost total conflict between the growth in patient requirements for care in that sector and a reduction, if anything, in terms of nurses involved. For example, in South Australia in low care, the number of people in hostels requiring a nursing home level of care has grown from 18 per cent of residents in March 2000 to 24 per cent in March 2001. In nursing homes, the top two categories of care have grown from 65 per cent to 76 per cent of the resident population over that same year. But at the same time, we had actually a small reduction in registered nurses and enrolled nurses in employment in aged care facilities—a complete reversal of the actual trend. I will stop there and will deal with any other issues in questions.

CHAIR—I have one quick question: can you tell us where the agency nurses are largely working in the public hospitals? Are they in high specialty areas or just in the general run-of-the-mill ward care?

Mr Bonner—They appear to be throughout the hospitals, although there is no doubt there are less and more popular areas of employment, so that, for example, orthopaedics seems to be an area which is not attractive to permanent staff and is more heavily reliant on top-ups than others. There are some specialist areas, no doubt, like mental health where we seem to have a high use of agency staff.

CHAIR—What about places like ICU?

Mr Bonner—I cannot offer you any firm evidence about that.

CHAIR—That is helpful. Thank you. Who is next?

Mrs Blott—Madam Chairman, senators, members of the public, thank you for this opportunity to speak to you today. Please excuse me reading my submission, but I am a little bit out of my league here today, I think. I am here to talk to you about my personal experience, but I am also here as the face of the ground floor, every day, common, run-of-the-mill nurse.

I am a registered nurse at Northern York Peninsula Health Service, which in its former life was Wallaroo Hospital. It is considered rural; it is close to two hours drive from Adelaide. I am the face of the person who delivers care 24-hours a day, seven days a week, 52 weeks a year, although not all by myself, I add. I work on Christmas Day, while the kids open their presents; I work at Easter, when there is an egg hunt on at home; I work on my anniversary, my birthday and my family's birthdays, as the job has to get done. I am here representing the nurse who will likely be your first point of call at casualty, one of those who will answer your call at two o'clock in the morning if you are not sure if you really need medical attention or not. I will deliver your children, ease your pain after your operation, no matter what time of the day or night, and hold your hand while you say goodbye to your loved ones. On any day, the patients in my hospital will include mothers and newborn babies, children with gastro and patients recovering from surgery, a heart attack or dealing with cancer.

Wallaroo Hospital cannot and does not specialise, due to bed numbers, but deals with the sick across the spectrum. Treatments are changing and equipment, when we can get it, is changing, and we have to keep up with it all. As nurses, we are not meant to care for clients outside our experience, use equipment we have not been trained in or administer drugs we do not know everything about. Who will educate us, though? Across the state, many assistant director of nursing, clinical manager and clinical nurse positions have gone and staff who provide education to rural areas no longer exist.

The training component of funding is now dealt out by our regional health board and mainly goes to areas of greatest perceived need. We, as permanent staff, are often faced with providing education and orientation to an increasing number of agency staff, who we could not survive without, but this is not necessarily the best way of providing long-term care. I do not believe that most workplaces would truly meet occupational health and safety requirements to provide a safe place of work. How can it be safe when we are working constantly under pressure which often becomes so bad that we take it out on each other? When we are involved in decision making, it is when we are over budget and facing more cuts. I personally believe that the term should be 'underfunded', not 'over budget'.

I have been a nurse for 25 years and I would like to tell you that I started very young. I always wanted to be a nurse. I wanted to help people and care for the sick. Unfortunately, I have come to resent a career that forces me to make decisions about the care I give, purely on its urgency, not on its need to be done. I resent the fact that my documentation does not chart a journey through the hospital, but charts things that may help me if we are sued.

My career forces to me to deal on a daily basis with unmet needs that at graduation I pledged to meet. I pledged to practise my profession faithfully—not difficult to do. I also pledged to devote myself to the welfare of those committed to my care—difficult when the care is prioritised and mainly depends on whether you are about to die. I can no longer meet the requirements set for me by the system or our health service. In the last three years, I have personally coped professionally with caring for my best friend as he died at 48 with cancer, I have cared for work mates as they lost their battles with cancer, I have delivered chemotherapy to others in my community who are facing their own battles and I have shared their joy when the debilitating courses were over.

What I, and many like me, cannot cope with is working day after day after day, trying to meet unrealistic government and public expectations which we know are going to continue. I cannot cope with a phone that interrupts me 40 times a day while I try to provide patient care, as we do not have a ward clerk any more to help screen the less important calls; besides which, there is no-one else in the building after 5 o'clock and on weekends. I cannot cope with not having the time, the staff or the staff mix to provide the care that all the patients deserve, not just the ones who will die if I do not get there.

I do not have the answers to these problems; all I know is that it is not nursing. I realise that some progress has been made and some recruitment and retention strategies have been implemented. The problem is that these people will not stay. The retrainees are mostly in the age group where, if they do stay, they will be retiring with the rest of us who will be going within the next 10 to 15 years.

I have reached a stage where last year leaving the profession was fast becoming an option. I hate the turn 'burnout' as to me it implies not coping, but when you no longer want to go to work, your only thought is what disaster awaits you today, and you start having panic attacks each day as you leave for work, you do start to feel burnt out. Life becomes one long round of working, depleted energy stores, poor sleep and a constant fog of worry. I do not even have the right to set the record straight because of the Public Sector Management Act.

In our hospital we have recently lost two registered nurses, one a permanent operating nurse and the other a midwife. The local doctor's clinic has had inquiries from three other permanent staff looking for alternative employment. I have been lucky enough to get a short period of leave to undertake a project in our region looking at another form of health care delivery. Amazing—isn't it?—when after 25 years the thought of tackling something totally outside my experience and sphere of knowledge and with huge expectations on the project still seems to be a job from the heavens.

After all this doom and gloom, I do wish to say that continuing in my career as an ordinary nurse is my aim. I am amazed by nurses' resilience, compassion and desire to make our health system meet the needs expected of it, often at great personal cost. Although nurses need more incentive to stay in the profession or to take it on, this is not necessarily about more money for nurses, but about more money to allow each and every one of us do the work we are paid for and want to do at an acceptable level. The problem cannot be fixed by buying in nurses from countries which probably need them more than we do, which seems to happening in the medical profession. It is at the end of each day that every one of you and your families who will be cared for at some time in the system must ask whether it will meet your needs.

CHAIR—If I was chastised to start with, I am thoroughly re-educated. Thank you very much indeed for that, and 'ordinary' is not a word I will use about nurses if I can help it ever again.

Ms Iliffe—Toni is going to mention what things are like in aged care.

Mrs Zuch—I will give this in shorthand, which is my normal style of talking anyway, because of the time constraints. Many problems have arisen in aged care since its reforms in 1998 and 1996. One example, and I will give you others, is ageing in place in existing facilities, where registered nurse cover for 24 hours a day for people who have high care needs is not ob-

tainable and as a result we are breaching a duty of care. The loss of CAM, SAM and OCRE means that we no longer have a clear nursing and personal care budget. Money is clearly being siphoned off into capital works due to certification requirements.

If certification is not realised, an aged care facility cannot apply for accreditation, and closure of the facility will occur. Rob has already spoken about the increased resident activity, but one of the major issues that we are facing is early discharge of residents from the acute hospitals. We are now looking after people who need intravenous therapy, subcutaneous infusion, pack feeds, palliative care and tracheostomy care. The RCS funding tool does not acknowledge that, and as a result we cannot employ more qualified people because the money is not there. In the low care facilities, over 25 per cent of residents are assessed as high care. They usually fall between categories 1 and 4, and the proportion is increasing every quarter. There is a public expectation: they demand champagne on beer money, especially in relation to accreditation standards. Registered nurses and management are working around the clock at no extra cost to meet the standards and especially all the documentation and the paper trails with which we have to demonstrate, we have to prove, what we are doing in reality.

As I said, the documentation is mainly accreditation but also the resident classification instrument, RCS, which is validated regularly by government validation officers. It is definitely punitive—every organisation loses money. Recently I had eight RCSs validated. Three validation officers came with their laptop computers and four were downgraded. They spent five hours on one case study. The category went down by two categories and I lost a lot of money.

Senator KNOWLES—What were the reasons for that downgrading?

Mrs Zuch—This one was in low care, where unqualified staff—by that, I mean personal carers—have to do the documentation, but the validation officers are registered nurses. Their level of understanding of articulating care in writing is of a much more sophisticated level than what the personal carers can achieve. So registered nurses are validating the documentation done by personal carers. I do not have enough registered nurses who can do all the documentation—it is humanly impossible. I have one registered nurse for 109 residents; it cannot be done.

More time is spent on documentation than on hands-on activity. Recently I had an agency staff member, as I do frequently, and I asked her why she worked for the agency. Her response was, ‘I come to work to nurse sick people, not to spend time behind a desk. I only have to do exceptional documentation, and I go home on time and spend quality time with my family.’ There is a massive shortage of RNs in aged care due to the uncompetitive wages and Rob has already talked about the discrepancy between the public and private sectors. I have been advertising for RNs since early November—the last time was a fortnight ago—and I have not had a response yet.

Professor Julianne Cheek has been doing a research project for two years within the aged sector to identify why there is a shortage of registered nurses, and it has been identified that the role of the registered nurse in aged care is changing and that it is far more complex than it used to be. There is also a perception of registered nurses in residential aged care as being devalued and the media, I am sure you will agree, has contributed to that perception. As a matter of fact,

Rob and I were at a presentation the other day and a reference was made to aged care as 'slut work'. Rosters need to be flexible to meet family, social and residents' needs, as well as the validation and accreditation needs. There are also the everyday demands of dealing with people who are dying—all our residents eventually die. Dealing with grieving relatives who are feeling guilty for having placed their loved one in residential aged care takes an enormous amount of counselling because it is still not truly acceptable to have mother or father placed in residential care. We are very strong on rehabilitation, even though we know the end of the road is the impending death of an individual. Also, the registered nurse is accountable for the work practices of unqualified staff.

As a result, the staff have a sense of powerlessness and a lack of control, and the media's perception of residential aged care is very negative and very destructive. Certainly, it does not encourage a registered nurse to apply for a position in aged care or an individual to take up nursing as a career.

Ms Parkes—I would like to make three points. The first is that staff development is recognised in all the literature as a key issue within job satisfaction arrangements and certainly nurses seek to have appropriate staff development and training for their work. It is also recognised in public places, so if a coroner's case occurs and a nurse has made a mistake, for example with a syringe drive or a pump, then the coroner makes a recommendation that all nurses should be appropriately educated in regard to that, and quite rightly so.

Similarly, the ombudsman in South Australia has recently made recommendations about education for hard shackling and restraint. DHS makes recommendations about how nurses should work with Aboriginal people and Equip Quality Processes make recommendations about how nurses should be educated to do a variety of things in relation to equipment. All of those things are quite right. I am in a job where I am responsible for over 2,000 nurses and for their education in one organisation. So every time someone says, 'The nurses need to be taught X,' I have to work out how 12 of us are going to teach 2,000 people across multiple shifts—and all of this to the same standard and so on.

CHAIR—Which institution is that?

Ms Parkes—Royal Adelaide Hospital, and its multiple campuses. The issue is partly one of resources. I think there is no recognition that, although we have shifted to a computer age and we have been given money to buy computers, unfortunately they do not last 10 years like a lot of old equipment did. So every two years you start running into trouble, because there is actually no funding for the ongoing upgrading and so on.

CHAIR—Where did you get the funding from to buy computers?

Ms Parkes—Because we are a training portion we actually train in some areas outside the hospital to try to earn an income in order to buy some of the things that we need to have inside the hospital.

CHAIR—I am glad I asked!

Ms Parkes—So with some of the things that we are delivering for our nurses, we will accept, say, nurses from the private sector who pay to come in and do that. We are delivering the education anyway, so we have additional people in the class who are paying an amount, and we basically try and save up that way. It is a more sophisticated version of the old lamington stalls, I think—I have raised so much money for hospitals through lamington stalls and so on! I guess my other point would be that the greatest difficulty is not always straight money.

CHAIR—Straight money as apart from what?

Ms Parkes—I am going to get myself in terrible trouble! As apart from—

CHAIR—I am wondering what bent money is coming through! But give me an alternative to straight money.

Ms Parkes—The ability to release nurses to go to education was what I was after. So the issue is not just the funding for the education but that, even if you can provide the education, the clinicians cannot be released in order to come to the education. What we do at Royal Adelaide—we have done it now for three years—is provide no nursing education from the middle of May to the end of July, because in winter the hospital numbers are so high and the nursing numbers are so low there is just no point in putting it on. We jam all of the rest of it into the rest of the year. So that is about staff development in general.

A second comment that I would like to make is about generational differences in nursing, and that has been touched on a little. I think that some of the research is starting to show that nursing is dealing with two major groups: baby boomers and generation X, as they are called—the under-34s. We have done some stats at Royal Adelaide Hospital. In our mental health and rehab areas it is predominantly baby boomers—around 80 to 90 per cent—which is actually a recruitment issue. If you are under 34 and you work there, most of the people you work with are probably your mother’s age. So there are a few recruitment issues about attracting young people to those areas. In North Terrace, which is your quintessential acute care teaching hospital, the numbers are about 53 per cent baby boomer and 45 per cent generation X. This means that about half of our nurses are under 34. In all of the literature I can find, both from a management and an education perspective, those groups of people have vastly different expectations and needs. So not only do we have to provide education to all of these nurses; we also have to provide it in two manners sometimes to meet the ways that they function.

You talked earlier about brand loyalty. I think that, on the issue of brand loyalty in the context of time balance and flexibility, the literature shows that the generation Xers do not have that kind of thing. They want to move around a lot more and they want to balance other things as well as work. I do not remember other things apart from work, but clearly they want to balance those things. So they choose things like the agency because it gives them the ability to do that. In fact, my understanding from a number of our nurses is that they do not go to the agency to earn more money; they earn the same amount but work fewer hours, and hours that suit them. So now they can actually balance out their lives, which of course is what the documents in our hospital say we should be doing anyway—having a balanced work life.

The second comment I would make is that we have been funded by DHS to provide a number of re-entry courses for registered nurses to do without fee. We find that the re-entry nurses are

very keen to come back. The kinds of things they are taken aback by are mostly to do with patient behaviour. Sometimes it is the lack of resources, but the degree of violence, the amount of use of illegal drugs, and what I would call a lack of social skills amongst a lot of the clients are things that challenge them. The work is also both physically and intellectually challenging, and that raises an issue in the acute sections of our hospital. If you are over 40, while you may well physically struggle with the level of work, you are probably at an intellectual and emotional life peak to handle it. The physical part is difficult. I think nursing is quite unusual in that people assume that physically challenging work is not intellectually challenging. I think the issue for nursing is that it contains both in many areas.

My third point is the issue of federal and state funding separations and what that means for nurses. I can give a couple of examples. At my hospital and several others, patients cannot be given more than three days supply of discharge medication. The rationale is that the hospital pays for the discharge medication; that is state funding. If the patient has to go to their GP to get their script filled in three days time, that is federal funding. It is a very smart move politically and not a problem bureaucratically, but it is the nurse who has to explain to the 80-year-old patient on Thursday afternoon why they have to go to the GP on the Friday or on the weekend to get the tablets that the hospital is currently giving them—but not enough—and so on. That is just one example that happens every single day, in a range of areas. Why can't you have a feeding cup, why can't you have this, why can't you have that—because of all those sorts of mechanisms.

My last comment is this: with the re-entry courses in the current circumstance, the state has funded the two major hospitals to provide fee-free courses. We tried to combine with an aged care area to do that, but two things happened. Firstly, the state would not fund it because aged care is not their area; secondly, when the aged care people applied to the Commonwealth, the Commonwealth would not fund it because, I guess, they did not see it as necessarily a problem, and also because the education was being provided by a state based provider. My comment is that there are major difficulties created out in the workplace by the fact that Health has this dual funding arrangement. As you would well know in government, not all money gets to its intended target area anyway. Even where money is allocated to a range of things, like staff development, a good deal of it seems to disappear along the way.

CHAIR—You mentioned the two major hospitals. Did you mean Flinders and the RAH?

Ms Parkes—Yes.

CHAIR—Ms Parkes, I would simply say that if you do not continue in nursing, you should certainly become a scriptwriter for comedy. It was extremely informative and it will probably stick because of the amusing edge to it.

Senator KNOWLES—I would like to ask about the aged care issue. One of the things that I think is very important is the question of excessive paperwork. If we were to make a recommendation, which I hope we will, that somehow there has to be a reduction in the paperwork, where would you suggest we start?

Mrs Zuch—There is repetitive documentation required in validating the RCS claim. For example, if we have a person suffering from dementia in the dementia unit, that person has

already been assessed as having a behaviour problem. But we need to demonstrate that that behaviour problem is consistent over a period of time. So it is repetitive.

Senator KNOWLES—Over what period of time?

Mrs Zuch—There is a flow chart over two to three days.

Senator KNOWLES—And then is there any need to follow that up with more paperwork?

Mrs Zuch—From the flow chart, we assess the problem, and this could have been done with documentation over 24 hours. We identify the problem, assess it, and develop a care plan—which is the nursing intervention and support necessary to curtail the behaviour problem. Then we have to review and evaluate to see if the plan is working, and on a regular basis.

Senator KNOWLES—How regular?

Mrs Zuch—If it is a case where a person absconds, and it is known by all that a person with dementia is non-weight bearing—but, because of their impaired mental capacity, they are not aware that they are non-weight bearing—we may have to use a civilised, acceptable restraint. It is advocated that we start reviewing and evaluating on a two-hourly basis.

Ms Iliffe—One of the other areas that the committee might consider is that we have had the RCS for quite some time now. It is a funding tool and it has 20 questions. Statistically it should be possible to reduce the number of questions so that the RCS becomes a funding tool and does not become a pseudo care plan.

Senator KNOWLES—It is pages long, isn't it?

Ms Iliffe—Yes, pages long.

Senator KNOWLES—What I am interested to know is how we can cut that down to do exactly what you are both suggesting and yet still have the same outcome as the funding tool, but achieved by making sure that nurses are nursing and are not pen-pushers.

Ms Iliffe—Statistically you should be able to reduce it to seven questions from 20.

CHAIR—If I could just interpolate here, and you might comment on this as well as on Senator Knowles's question, the trouble is that the very good nursing homes and the people who are practising good care are all being punished to try to weed out a percentage of those aged care facilities that are pretty awful. Would you comment on a better way of trying to detect the baddies rather than punish the goodies?

Senator KNOWLES—Just before we go to that question—did you say seven questions?

Ms Iliffe—Yes.

Senator KNOWLES—Would you care to send us a note of your suggested seven questions?

Ms Iliffe—Yes, I think you will find that that work is already being done internally.

Senator KNOWLES—By whom?

Ms Iliffe—By the department.

CHAIR—Federal?

Ms Iliffe—Yes, the federal department. I am a member of the AMA committee on older people. Two years ago we asked whether work had been done statistically to reduce the number of questions. Statistically, when you have a certain amount of data it has to be possible to pick up those trends that will give you the same outcome. They said, 'Yes, it is possible', but they were reluctant at that time to reduce the number of questions for two reasons: one was that they did not want to introduce more change into the system and, secondly, they thought they were collecting a lot of valuable data that they might want to use at some stage. I do not think those reasons are good enough now.

Senator KNOWLES—You are not Morgan research; you are trying to do something useful for the community I would have thought.

Senator TCHEN—Do you know how many of those 20 questions are due to this legal protection issue?

Ms Iliffe—I think it is a funding tool. It should be irrelevant. You have a care plan. At the moment, because you are doing so much documentation for the RCS, it is almost being used as a pseudo care plan which it was never meant to be and it is not designed to be. It does not pick up all aspects of care. So it is your care plan which is your legal tool. The RCS is a funding tool and should be limited to that.

Senator KNOWLES—I come back to the issue that Senator Crowley raised because I think it is a crucial one for weeding out the crooks or the less desirables and also trying to create a better impression of aged care because that then will hopefully lead to more RNs wanting to work in the industry if we can also dispel the disparity in income. I think this media push that you talked about is a very real thing. When certain incidents happened the year before last, perceptions were that people had been dunked in a bath of kerosene as opposed to a teaspoonful of kerosene in a bath. Therefore, everyone then thought that all aged care places did to shut their inmates up—for want of a better expression—was to chuck them in a kerosene bath. That is just working so counterproductively to what all the good people are wanting to do. How do we solve that problem?

Ms Iliffe—I think it is the accreditation process that is critical as far as weeding out the poor quality providers goes. Accreditation is something that their federation, the ANF, has always supported. We are accustomed to accreditation in hospitals and community health centres. The difficulty that we find—and a lot of registered nurses are auditors and we certainly have had a lot of feedback from our auditors—is that there is not enough specificity. There are no guidelines to support the interpretation of the standards so there is inconsistency in the way the standards are applied. That is something that is relatively easily addressed and it is addressed over time.

This is the first time aged care has gone through the accreditation process and it takes time for that process to become bedded down. Maybe Toni would like to make a comment from a practical perspective, but I think the focus must be on more spot checks, perhaps more frequent accreditation for people you have some doubts about and for people who do not pass particular standards, to weed them out. At the moment you have to pass a number but if you fail some of that then you still pass. My view is that you have to pass them all and, if you do not pass all, then you should be reviewed on those you fail. Even if you still get an aggregate to be accredited, you still must need to pass the ones you have failed. But that does not happen.

Mrs Zuch—I support what Jill is saying. Nurses in the main have been educated to document for care and nursing not for money. It is against our code of ethics; money does not come into it. I support accreditation. We worked around the clock achieving it; we met all our standards. Most nursing homes in Australia did. People are very committed. Most nurses believe in it and support it. We have become very creative. We have become competitive with one another—that is very healthy. I believe accreditation is the process that sorts out the good from the bad. I feel very strongly about that. That also goes for our accountability with our funding. The accreditation process should identify where perhaps there is exploitation of funding and then we can do away with the current excessive documentation required for the RCS.

Senator KNOWLES—But how do we do that and not create more paperwork to achieve that end?

Mrs Zuch—We started, as you know, in 1984 with the RCI. I believe the Commonwealth government has enough data to measure the average cost per resident in regards to nursing and personal care. I believe we could use that as a benchmark. We now have 17 years of data; we should use that.

Ms Parkes—I would like to make a comment, perhaps separate from accreditation, but addressing what you are saying about weeding out difficult places. I also happen to be the deputy presiding member of the Nurses Board of South Australia. One of the things you find with the Nurses Board is that you get quite a sense of what are likely to be less than good health care institutions because of the nature of the reports that come in. A number of reports—whilst we can only deal with the nurses' behaviour—are clearly also systems issues, but the Nurses Act gives the board no power to make any comment to organisations. I rather suspect, as a side issue—not the main issue, but as another option—that if nurses boards were able within the acts to make comment in the way the Coroner does—as soon as the Coroner says anything, everybody jumps to and changes their system—that would be another way of actually working through how you might deal with those organisations.

Senator WEST—Let me just turn that around a bit because we had similar evidence from Queensland yesterday. If you have an institution which is failing accreditation, what can you do to go and look at the practices of the nurses? Do you have to wait until there is a complaint about an individual nurse or can you almost pre-emptively step in and look at the practices of those nurses in those institutions, either to back them up and say, 'You are doing a good job but it is the employer, the boss', whom you cannot take any action against, or, 'Yes, you can actually improve the situation here. Your professional standards are not up to scratch'? Do you have the ability to do that?

Ms Parkes—No. You are quite right. You can only deal with a complaint as it comes in.

Senator WEST—On an individual nurse, not on an institution?

Ms Parkes—Not on an institution. I guess I am not suggesting that there be a direct link to the accreditation passing or failing but rather that this is an alternative mechanism, because you do discover information which you are then powerless to use in the system.

CHAIR—I wanted to add a further one to that which we heard yesterday. I understand that under the nurses boards in other states—I read the information very closely last night and, in fact, you just pre-empted my question—you are also responsible for accrediting courses and the appropriate clinical placement.

Ms Parkes—Yes.

CHAIR—If evidence comes to you that course X from institution Y is sending people for clinical experience in nursing home or aged care facility Z—

Senator WEST—Or hospitals.

CHAIR—which is very bad, why can't you act through that route?

Ms Parkes—I guess you could. I suppose the difficulty is that the course provider is the person applying for accreditation, so that would be the universities or, for example, the Royal Adelaide Hospital or any registered training organisation that trains ENs. So we do have a difficulty in one or two nursing homes, but the difficulty is more that the EN student placed there is asked to do the work of a carer. So as well as nursing, they have to wash the linen and clean the kitchen and so on. It should be that they are just marked as a bad nursing home as such.

CHAIR—Don't distract yourself, Ms Parkes. Why hasn't the board got the capacity to say, 'This place is below standard. Off the record or on the record, I am going to ring someone'?

Senator KNOWLES—And do not send anyone there.

Ms Parkes—It does do that when there is a complaint from the area. The staff from the nurses boards do ring the nursing home or the hospital, but I would say that the accreditation process for courses is not so stringent that it says exactly where all the students are.

Senator KNOWLES—No, what we are actually trying to say is that, if you get that information, why wouldn't you then contact the university and say, 'Whatever you do, don't send anyone for clinical practice there because it is a rotten place'?

Ms Parkes—I guess because the board comes from a very legal jurisdiction and would ask the question: have we actually got the evidence? If it were really blatant, you probably would but, as I say, it is more likely to be blatant in a place that does not take students. It is more likely

to be blatant in places that are hidden from that kind of view of people coming in and going out and so on.

CHAIR—Ms Iliffe or Ms Thomas, did you wish to make a comment there?

Ms Iliffe—Just that it is not usually the course that is the problem. I guess, from the board's position, anyone can make a complaint to the agency or to the department. I know that in our other branches they have been the drivers, with complaints about facilities to the agency and to the department. Lee, did you want to comment on what is happening in South Australia?

Ms Thomas—Yes. We certainly do through our membership, on a reasonably regular basis, have complaints about particular nursing homes' practices. Once we have some clear evidence—and it is usually fairly compelling—we have in the past spoken to the department in regard to those areas and made a report.

Ms Iliffe—I want to comment in relation to that. When you make a complaint to the department, one of the problems that we had last year—and I am reasonably reassured that it has been addressed, but I am not convinced—is that the state departments did not have a QA process in place to check which complaints they were referring on to the agency and which ones they were not. So somebody was making a decision, which certainly the nurses felt was inappropriate, that that complaint was either not so serious or it could be dealt with in a different way other than referral to the agency. There are many instances where the branch has made repeated referrals because the state departments have decided that they will handle it rather than refer it on to the agency.

CHAIR—What does 'agency' mean—

Ms Iliffe—Sorry, the accreditation agency.

CHAIR—No. It is just that the language is very complex and we like to be precise.

Ms Iliffe—The Aged Care Standards and Accreditation Agency is what I was referring to.

Senator LEES—I think you need a direct route through to them. You need a process where you can pass information directly to them and then leave it to them to make decisions and checks et cetera.

Ms Iliffe—Or some confidence that there is a QA system in place in the department, or that your opinion is given some credence and you can say to the department, 'This is one we are really worried about; nurses are at risk here; we think this should go to the agency,' and some weight is given to that.

Senator LEES—So, to get back to Senator Knowles's question, we could replace paperwork with some better processes at state and federal levels for actually acting on formal complaints that have come through the nurses board or the union—or however they appear on the horizon?

Ms Iliffe—Yes.

Senator KNOWLES—Putting all the pieces of the jigsaw together.

Ms Iliffe—Yes, that is right.

Mr Bonner—You also have to clarify the role of the agency and the federal department. When we discussed this issue with the federal department and the agency in February, one of the issues was that they were not clear about one another's roles in dealing with complaints or the quality assurance process. There was some dispute between the two organisations during our discussion about whose job it was to do certain things. There certainly needs to be some further clarification about that so that it is clear to everyone where you need to go with those kinds of complaints.

Senator KNOWLES—What protection would there be under the scheme you are proposing to prevent someone from being vindictive—for example, if they had left on bad terms or something—and wanting to get a nursing home into all sorts of strife? How could we protect against that possibility?

Mrs Zuch—The complaints mechanism is fairly concerning, because it happens that people are vindictive. They lodge a complaint with the complaints department, the complaints department would then give me a call and identify the allegations, and then I have to demonstrate with lots of documentation that we are innocent.

Senator KNOWLES—That is what I was getting at: it has the potential to create more and more paperwork.

Mrs Zuch—An enormous amount. I will give you an example. Because I did some restructuring, a staff member resigned feeling bad about us. Although we have no proof, we feel that she is the one who lodged a complaint with the complaints department. The allegations were that we denied residents an outing on a bus. We have a bus, we have systems in place, we have social calendars in place, and I have all kinds of mechanisms in place so that I do not breach my duty of care when residents are invited. The list goes on and on. Two members of the department met with me, and I had to articulate what was in place. I got out all my manuals, the whole caboodle, including lists of the people who go on the outings, and then I had to follow up with a thick document to validate that we had a system in place that gave everyone the opportunity to go on a bus trip.

Mr Bonner—That is the case. The current system allows complaints to be notified on a completely anonymous basis, so anyone could ring up and make allegations that then have to be investigated. I do not believe that would be altered significantly. If you have a degree of vindictive reporting, it is extremely small. The number of complaints overall, when you look at the department's formal complaints process, is not vast. The department report to us on a quarterly basis through a liaison group. They can identify, usually pretty quickly, through their usual processing where something appears to have come from a disgruntled family member, former staff member, or whoever it happens to be. It does not seem to be an enormous issue, although no doubt it is if you are on the receiving end of the bad allegation.

Ms Iliffe—There is a very fine line between trying to identify vexatious complaints and making sure that people are able to complain if they have a legitimate complaint. I think the

difficulty is in what the department requires of the employer in the first instance. I think what Antonia said is right—we hear this from employers all the time, and I have a fair degree of sympathy with them—the amount of proof they have to give that the complaint is a vexatious one is probably much more than is necessary for an initial fact finding. The process in a lot of other complaint areas is that you do an initial fact finding and, if you are reassured that it is a vexatious complaint, the process ends there, instead of putting the burden on the employer to prove that it is a vexatious complaint. I think it would be better to have a fact-finding step where you sat down with all the parties and said, 'This seems to me to be vexatious. We will just leave it at that.'

Senator KNOWLES—So a two-stage process?

Ms Iliffe—Yes.

Ms Thomas—I agree with that.

CHAIR—I am just concerned a little bit about the time. We are going to have an opportunity to make sure we have got time, even if we have to go over—it is just too important. Senator Knowles, you had a couple of other points you wanted to raise. Come back to them if we possibly can. I think you said that aged care has turned out to be so important. It has been very useful.

Senator KNOWLES—I think the aged care issue for us is particularly important and that is not to dismiss any of the wonderful work that nursing is doing generally. This is an area that we have not necessarily had the time or the people before us with the knowledge to be able to concentrate on, so I apologise for taking that length of time on aged care.

Senator LEES—My concern as we have been through these hearings is that we seem to have a growing pool of completely unqualified people. We heard yesterday in Queensland them being referred to as POTS—people off the street. With the shortage of nurses—Mr Bonner and a number of witnesses have talked about it going up to 1,500 within a couple of years—the pressure to find POTS is going to increase. They are actually going to be out encouraging attendants or assistants. Unfortunately they sometimes add the word 'nurse' which gives a difficult impression. What is the union going to do about the increasing pressure and the increasing number of people who have absolutely no qualifications walking into not just nursing homes but potentially hospitals as well?

Ms Iliffe—We do not use the term 'POTS'. We say 'unlicensed nursing' or 'personal care assistants' and we consider them to be part of the nursing family. They are entitled to be members of our organisation and we do provide cover to them.

CHAIR—Is that across the country?

Ms Iliffe—It is increasingly.

CHAIR—In some states not—

Ms Iliffe—New South Wales, Queensland, Victoria and South Australia now, and certainly in Western Australia and Tasmania there are moves towards that. So with the change in the sort of work that that worker is doing, as it becomes more and more nursing work it is important that they become part of the nursing fraternity so that you can have input into their education and also input into the sort of work that they do. Because nurses are delegating care to them you have to be sure about their education.

CHAIR—I am sorry, I have interrupted Senator Lees.

Senator LEES—What is their education? We seem to find in some places that it is not—

Ms Iliffe—Their education is Certificate III.

Senator LEES—Is that compulsory?

Ms Iliffe—No, Certificate III is not compulsory. It has not been made compulsory by employers or by governments but we have four branches of our federation who have actually implemented Certificate III—New South Wales, Queensland, South Australia and Victoria have all become registered training organisations and developed and provided Certificate III courses for the unlicensed worker. In South Australia I think you have some figures on the numbers who are actually doing that. It is becoming much more rare for people not to have education.

Ms Thomas—In this state, Senator Lees, unlike many others, we have around 70 per cent of that personal care assistant category actually trained to Certificate III level as a minimum. What we are seeing happening more and more is that employers are making that minimum level Certificate III a requirement of employment.

Ms Iliffe—I think, too, that it is not just the Certificate III but that it is articulation into an enrolled nurse course—

Senator LEES—That is my next question.

Ms Thomas—With transition.

Senator LEES—We talked this morning with the universities.

Ms Iliffe—I think you would find the same percentage in New South Wales as there is in South Australia of the number of unlicensed workers who have a Certificate III. In New South Wales they developed a course which was based on a person's experience so they fast-tracked through the Certificate III depending on the experience that they had in the workplace.

Senator LEES—What is your role as a union here in South Australia in looking at that ladder and making sure people can at least get on it at Certificate I, II and III level but then can move off to work or go back into an enrolled nurse position and off to work, then go back into registered work and then go back in at the top end in terms of additional qualifications? Do you have a role in that?

Ms Iliffe—Absolutely.

Senator LEES—What is it?

Ms Iliffe—It is not just in developing the courses at a Certificate III level but negotiating the articulation into an enrolled nurse course and lobbying for positions in enrolled nurse courses. For many years, some states—and South Australia was one of them—did not educate enrolled nurses at all and were reliant on New South Wales and Queensland to produce the enrolled nursing work force which was very short-sighted. I think, now, there is a much greater recognition that we need to not only educate adequate numbers of enrolled nurses but look at their role and their scope of practice, because it is quite clear that they are capable, through education, of taking a greater role in the workplace. There are also very good articulation programs between enrolled nurse programs and registered nurse programs, and, in some instances, enrolled nurses get up to 12 months off their three-year course. I am not sure what your articulation programs are here—a little more?

Mr Bonner—No.

Ms Iliffe—About the same?

Mr Bonner—You can generally get about six months between the enrolled nurse and RN programs. The Certificate III program for aged care workers is linked with the Certificate IV in nursing for enrolled nurse entry at the TAFE and RTO levels, as well. So there is a flowthrough.

Senator LEES—I am just looking at our time. Do you have a chart that will show us—

Mr Bonner—Yes, we can provide that.

Senator LEES—and looking at the shortage we have, both of enrolled nurses and of registered nurses. We are looking at ideas for getting people on at various points and moving them up the ladder to areas of shortages. Can I leave that with you?

Mr Bonner—Yes. In fact, that is happening to a significant degree already.

Ms Iliffe—It is important to remember, though, that the unlicensed worker works predominantly in aged care and in slow-stream areas. In acute hospitals, because of the faster throughput and the higher acuity, it is usually fairly inappropriate to have an unlicensed level working in the acute sector.

Senator LEES—That might be something the union could look at as an issue that you could work on. How many enrolled nurses each year would get into a registered nurse's course with some acknowledgment of previous experience?

Ms Parkes—It would be hard to know the numbers because they do not have to identify as coming from there. Certainly there is one university here—one of the two undergraduate programs—which is very keen to take enrolled nurses.

Senator LEES—Part of the trouble is that, on your figures, it looks like we need about 460-odd per year just for the normal turnover. If they are going to be poached into the registered courses, we are going to further exacerbate the situation.

Mr Bonner—You get the same issue at the enrolled nurse level. The last figures I saw from the TAFE showed that between 30 per cent and 50 per cent of their enrolled nurse numbers were coming from people with Certificate IIIs as care workers. So we are continually drawing through the system to replace our existing work force.

Ms Iliffe—But we are able to fast-track them. We can compensate them, because if they have done an enrolled nurse course they spend less time in their undergraduate nursing program. So there is a bit of an offset—not much, but a bit.

Ms Parkes—As an educator I would like to mention that there are some limits to increasing the number of enrolled nurse people going through. They need a clinical placement that gives them sufficient experience, and that is what we are running into trouble with, too.

Senator LEES—Does that mean money, as well, in terms of financial support for people who are supervising or training them?

Ms Parkes—Not necessarily. Royal Adelaide happens to be a RTO and it therefore trains enrolled nurses. It is done in a way that allows them to work part time and do their clinical work part time, so they can manage that. Because of the number of beds that have been closed, the issue is the sheer number of places in acute care in which to put them to give them sufficient experience for that six weeks. At the moment we have them jammed in. One works Monday, Tuesday and Wednesday—they are supernumerary—and the second one is there Wednesday, Thursday and Friday. Otherwise, the ward becomes full of students who are supernumerary and there is not enough staff to look after them, and it is a drain on clinical staff to look after students. There is a bit of a balance issue; otherwise, we would jam in as many people as would come.

Senator LEES—So to meet this decline of maybe as many as 30 per cent in 10 to 15 years, we basically have to start tomorrow.

Ms Thomas—Yesterday.

Senator LEES—We are getting a sense of the urgency of this as we move on. A couple of issues were raised as you made your introductory statements. There is the Victorian experience. We have had anecdotal evidence of how much better it is when you reduce the numbers that people have to cope with. Is any research being done? Can you give us any statistical details?

Ms Iliffe—There are numbers and those physical numbers can be provided to you. About 2,500 nurses came back into the system.

Senator LEES—They came back into the system because the staff rate—

Ms Iliffe—Because they knew that they were going to have enough staff to do a decent job. That is what it really amounted to.

Senator LEES—To actually get the job done.

Ms Iliffe—There are statistics, and I can give you the exact figures.

Senator LEES—It would be great if you could pass those on to the committee.

CHAIR—Following the question I asked, were a lot of those nurses, who came back into the system, from aged care?

Ms Iliffe—It was a small percentage—not a huge percentage. A larger percentage were nurses who had reduced their hours or were working for agencies. But there was a small percentage who came back from aged care.

Senator LEES—This brings me to my next question. Here in South Australia, we are 500, 600 or 700 short of registered nurses at the moment. How many are in the agency pool? Do you have any figures on that or on how many are registered but are not in any pool—those who are just sitting on the sidelines, hoping things will get better?

Ms Iliffe—I am not sure about South Australia—Lee can answer that.

Senator LEES—I can leave that on notice.

Ms Iliffe—But we did bring some statistics for you, which I will leave with you, which give the overall national figure.

CHAIR—Do we have any state breakdown at all, because that would be helpful?

Ms Thomas—I think Rob Bonner has a document that can help you. I have just put him on the spot—he is not going to be happy with me.

CHAIR—We heard in Victoria, for example, that there are 70,000 registered nurses on the books but only 50,000 are working.

Ms Thomas—In this state, we know that there are around 23,000 nurses and approximately 15,000 are working. I can confirm those figures for you and I am happy to do that.

CHAIR—If there are 23,000 nurses and 15,000 are working, that leaves about 8,000 nurses sitting around, twiddling their thumbs.

Mr Bonner—About 13 per cent of the people registered are not currently actively in the nursing work force. For enrolled nurses, I think it is down to about seven or eight per cent. Nevertheless, there is a substantial pool of people in both categories who are not presently active in the nursing work force, but we do not accurately know how many of them are interested in re-entering if things are right. It would be fair to say that there would be a number of them.

Ms Iliffe—Nationally, it is 10 per cent.

Senator LEES—Having some managers and researchers to go and talk to them—

Mr Bonner—Yes, and the agency pool is very big.

CHAIR—You are staying, so you are a bad example, but what would we need to do to get you back if you had gone?

Mrs Blott—My biggest problem, at the end of the day, is feeling helpless—that I had 28 people in my ward and that I had been able to spend any reasonable amount of time with probably only three of them. Luckily, I have some very competent enrolled nurses who do their whole day's work with me barely seeing or speaking to them, unless they have a problem. The only time I see some patients in the day is when I do my 8 o'clock drug round in the morning and, unless they are bleeding all over the floor or doing something equally as dramatic, I do not get back to see them again until 1 o'clock when I give them their lunchtime tablets—that is, if they have any—and then I go home, sometimes a little late, without having set eyes on them again. There are just not enough people on the floor to care for the sick people that we have in our hospitals now.

I have been nursing for a long time. When I started, back at Wallaroo Hospital about 16 years ago, we had a medical ward full of people who would be there for three months because they needed leg dressings four times a day. We now have excellent community services who look after those people. The only ones who come into hospital are those with extreme needs—people who have major surgery and are there for only two days and then go home. We only have people in hospital with high needs.

CHAIR—So you are principally saying to us that, if you really want to attract nurses back into the profession, you need more nurses to make it a job-attractive situation.

Mrs Blott—That is right. That is what is driving people away—it makes us feel like we are not coping, but it is not actually us that is the problem. You have this ongoing feeling—you just feel helpless, you feel useless—and you do not have time to think at all through the day or to plan your day. Every time you turn around, something else is happening; you have another four patients coming in on your shift. We are a small hospital, but our turnover is just amazing. You just do not get time to care for patients at an acceptable level. The fact that you have not set eyes on patients who you are legally responsible for or had time to supervise the enrolled nurses that you are also legally responsible for is a worry. We are meant to be supervising.

CHAIR—Thank you, Mrs Blott. We are getting some fleshing out of the statistics.

Senator LEES—I will finish here, as Senator West also has questions. Looking at VET in Schools, which was mentioned by the previous group, what experience or involvement do you have in that area? What is happening in South Australia in that area?

Ms Iliffe—From a national perspective as opposed to a South Australian perspective—and I will ask Robyn or Rob to talk on that—the federation has a view about VET in Schools: we support it; however, we are really concerned that there is sufficient staff in the workplace to give a quality experience for the student, that the workplace is appropriate for the level of emotional development of the student and that the program is a quality program. They are the

things that the federation wants to see in place. There is nothing that will drive somebody further away from nursing than if they have a hideous VET in Schools experience. In saying that, there are some really good models in a lot of states—

Senator LEES—We seem to have found it in aged care rather than anything else. Is that usual here?

Mr Bonner—We have had a mixture of acute hospitals and aged care. The problems we encountered were that there was at least one place using traineeship systems to support the VET in Schools program, which meant that people were emerging from their high school program with a Certificate II in Community Services (Aged Care Work) which then precluded them from getting access to traineeships for Certificate III or IV level qualifications which, of course, were the standard being required by the employer for vocational entry. We have done some negotiations of late, and that has now been withdrawn, so the VET in Schools program is now going to operate without traineeship options open, which is helpful. The other problem is that it has been used for so-called 'difficult students' who are not coping with traditional academic programs—

Senator LEES—'Let's get rid of them!'

Mr Bonner—When you are trying to use this as an entry to the profession, that is probably the wrong way to go. We have some difficulty with the selection process, and there have been problems with people being given unrealistic expectations about what is coming out of it. We had one group, for example, that thought they were getting some sort of accelerated or favoured access into the university program if they did their VET in School which was not the case at all. There has been a number of issues that we are working through with the ITAB and with employers at the present time.

Senator LEES—Do we put them on the continuum in terms of the ladder so that they can see where they are going as well?

Mr Bonner—Yes. But one of the difficulties we found when we time-laddered that process was that, if you went through the two-year VET in Schools, then did your Certificate III, then did your Certificate IV and then did your RN program at university, it took you between 6½ and seven years to get somewhere that could have been achieved three years after your matriculation. It is not necessarily a useful use of resources or of student time to encourage people who want to be RNs through that kind of program. But if you have someone who is unsure, then it may well be an appropriate option to push them through VET in Schools into enrolled nursing, for example. It is not an ideal solution for the work force problems though.

Senator WEST—So you have difficult kids and difficult patients.

Ms Parkes—Challenging behaviours, we call them.

Senator WEST—Thank you, I was trying to think of the right words and be polite about it. Mrs Blott, can I go back to your reminiscences? I think I can share with you the fact that 10, 15 and in particular 20 years ago, you did have patients in your wards for a long period of time. Often they would be acutely ill, but you also had them in the recovery stage when they required

less of your time. You got to know them better as well. What sort of factor is the constant pressure of always having acutely ill patients with no respite for, say, 60 per cent of them on the road to recovery?

Mrs Blott—It is really wearing, although I do not advocate leaving people in hospital for three months so we can have an easy day.

Senator WEST—No, I am not saying that you would!

Mrs Blott—Even a few years ago—maybe not quite as long as that—we tended to have more peaks and troughs as well. Winter was a bad time in hospital; we had a lot of medical clients. However, you might have a week or two when you were not as busy, and people would recharge their batteries and they would get their morning tea and all those sorts of things—although we have to have morning tea, I must say. But it is just the constant turnover all the time, and only seeing people when they are acutely ill and encouraging them to go home sometimes before you think they really should. Certainly, in the country, you are often sending them home to very little support. We do have very good community health services, so we are probably better off than thousands and thousands of nurses out there.

Senator WEST—But are you burning them out?

Mrs Blott—Yes, they are now starting to have the same problems that I guess we have faced in the last 12 or 18 months, where they do not have the staff to provide a service. So instead of being able to help someone with simple things like showering four times a week, now these people might only get showered twice a week because you have to allocate your resources. A lot of time and money is being spent on alternative dressing types, so instead of visiting someone once a day—which really is not asking that much—you are putting on very expensive dressings that mean you only have to go once every third or fourth day or once a week. While that may be good for the system, I do not know that it actually proves anything to the clients. It means that your nursing, both in the community and in the hospital, has become extremely task orientated. You do not get time to do the nursing things such as just saying ‘Good morning’ to someone or asking, ‘How’s your family?’ when you go past their room.

There is a big problem with discharge planning. That often comes up because people are only in while they are basically unconscious in theatre or doped out with pain relief and then they go home, so you do not have the time to really discuss discharge planning with them and how their family are going to manage or what they are going to do about their medication in a couple of days. For example, it may be a Friday afternoon and they are going home. They are going to need pain relief and the chemist in the country is only open for a few hours on Saturday mornings. There are all those sorts of issues that you do not have time to deal with. We should do that—it is part of our job—but we just do not get to do it. It is just the constant pressure of very sick people in for a very short time.

You then have to do all the paperwork. If it is not written down it is not considered to have been done. We do not have anywhere near the problem that aged care has in documentation, but we still spend a lot of time providing care and documentation purely to protect our backs as well. That is happening increasingly, certainly in the country, but it must be worse in the city. Those are the sorts of issues that you have to deal with day in, day out.

Senator WEST—Can I pursue the issue of unqualified staff, particularly in the aged care area, in community packages for people being cared for at home? What is happening in terms of there being adequate supervision by RNs and ENs?

Mr Bonner—There are over 3,000 full-time equivalent personal care workers and 3,000 full-time equivalent nursing and personal care staff in aged care in the state, so a good 50 per cent of the work force falls into that unlicensed care worker category. Within community aged care packages, that proportion is significantly higher. So almost all the care packages are being delivered by unqualified or unlicensed personnel, mostly with completely inadequate supervision of their care by registered nurses, to the point where a number of the aged care providers in this state just will not get into the business of aged care packages, because they are not satisfied that they are actually able to give the quality of care program that would be required if they go into it with the current level of funding and with the current arrangements.

CHAIR—We need a resolution for Channel 7 to film. There are no objections, so you are entitled to go ahead.

Ms Iliffe—I think one of the things with the aged care packages is that there are the community aged care packages and there are the extended care at home packages. Because they are funded formally by the government, there is the opportunity, if there is the will, to have some guidelines about what sort of staff should be involved and what sorts of supervisory arrangements need to be in place. The greater need is in the home and community care area where there are a lot of smaller non-government organisations. There is not the same opportunity there for scrutiny of the people who are providing care or the opportunity to put requirements and guidelines in place. From the Australian Nursing Federation's point of view—and I would be interested in the South Australian branch's comments—we have great difficulty tracking what is going on in the home and community care area. Conversely, in the DVA area, we do not have any difficulties. It seems that one section of the government has some quite good processes in place in that they involve us in the development of their guidelines—the aged care sector also involves us in the development of their guidelines and we were heavily involved in the accreditation standards—but there is another area where not only do they not involve nursing people in the development of their guidelines, they do not seem to have any guidelines. They do not use their own resources. There are very good guidelines in DVA but they do not exist in home and community care. You would think that they would share those resources. The HACC area is more of a concern, from our perspective, than the aged care area, even though we are concerned about the aged care area.

Senator WEST—Unlike the accreditation for nursing homes and institutions, there is no accreditation for the standard of care that is given under these packages or in the HACC?

Mrs Zuch—What our organisation is doing with our community packages is credentialling the care worker, but that puts an enormous burden on the registered nurse because she retains the accountability and she is not there to do the direct supervision.

Ms Iliffe—It would be quite simple for the accreditation process to incorporate those but there is additional work involved in that, of course.

Ms Parkes—The implication of that from the point of view of the Nurses Board is that a registered nurse comes before the board and the unlicensed worker is not covered by the board at all. They may have a qualification, like a certificate 3, but they are not registered or enrolled.

Senator WEST—And, basically, the only legal action that can be taken against them would be a criminal negligence type case because it is either all or nothing.

Ms Iliffe—Or discipline in the workplace.

Senator WEST—The RN can be disciplined for quite minor things—

Ms Iliffe—That is right.

Senator WEST—But the unauthorised or the unregistered worker is not covered by the board.

CHAIR—Is there any suggestion that you should look to taking registration off such people? If the ANF now covers such people, why doesn't the board?

Ms Parkes—You may need to ask the board that, Senator—

CHAIR—You are quite right.

Ms Parkes—However, I could say, on the ANF's behalf, that the ANF have indeed lobbied the Nurses Board of South Australia for them to extend their coverage of the Nurses Act to those workers.

Ms Thomas—We have approached the board on two occasions on behalf of personal care assistants in this state, and talked to the board generally about regulation of that group of worker. We believe that under the current Nurses Act 1999, there could well be provision for them to be able to do that.

Senator WEST—Regarding these packages in the HACC program, how much social isolation is that causing for the patients—that is, clients; I still think of them as patients, sorry.

Mrs Zuch—There is the potential for social isolation because nowadays all the neighbours are at work. The other thing that we are concerned about is elder abuse. Unlike residential care where the peers are there and act as an advocate on behalf of a resident, elder abuse cannot be monitored within a home environment unless that client can articulate it. I would imagine there would be quite an extensive process involved in validating such allegations.

Senator WEST—I might leave that, in view of the time.

CHAIR—We have got close to the end of our time. I wanted to ask two questions. Could you expand on your suggestion that

> ... the Australian Industrial Relations Commission ... be empowered to set wages and conditions of employment for nurses that are in the public interest.

Mr Bonner—This is an issue that goes to the way enterprise bargaining has or has not worked in our industry. It has certainly been a significant problem, for example, in the aged care sector, which has led to the current disparity, and we have been involved in discussions with the department over some years. The funding mechanism used to be driven by award based movements in wages so that the federal indexation system would follow award based increases in rates of pay. That is no longer the case with enterprise bargaining agreements, which means that the system no longer keeps pace with the needed growth in nurses' wages.

We have been trying to grapple with that issue and have suggested that a return to an award based system would be an appropriate mechanism for nursing. It would allow cases of disagreement over wage outcomes to be taken to the Industrial Relations Commission without going through the kinds of processes that are required in the Workplace Relations Act at present—which effectively are for there to be a process of dispute that breaks down and for the industrial commission to then determine that there are no other alternatives but to intervene in the process. So going back to an award based system for nurses would allow greater consistency in argument across the country.

CHAIR—That is very helpful. The other thing I wanted to ask about concerned this interesting question of IT. I think Ms Parkes mentioned computers—and I did write that down—particularly the funding of them. As I understand it, every general practitioner in this country who saw fit to apply was provided with $3,000 to assist them with acquiring the hardware necessary to have the software. Has there been any similar funding for computing provided to nursing?

Ms Iliffe—Absolutely not. Not only that; for whatever reasons, nursing has really been completely excluded from the loop at a national level. In my opening remarks I said that that is one of the things I would like to see come out of this committee—just some recognition that it is much more cost efficient to look at nursing from a national level. I had a meeting yesterday with the consultant that is doing the review of the National Health Information Management Advisory Council. We have written on several occasions to the council asking for there to be a nurse representative, but we have had absolutely no success in having a nurse representative on that council. So it is not just the provision of the IT—which we do not have anything of; we do not have any input into the development of programs that, at the grassroots level, nurses are going to have to use. It is so frustrating. I said to them yesterday, 'Nurses are like the invisible people in the health system; we make up 45.1 per cent of the work force but we are really invisible.'

Senator KNOWLES—This is the principal nursing officer that you referred to as well in your submission?

Ms Iliffe—Certainly that is a key thing. If we had a principal nursing adviser—and we have done some calculations which are in our pre-budget submission, and I have brought a copy of that—it would be half a million a year. Half a million annually would provide us with the voice at Commonwealth level to start lobbying on behalf of nurses and to be able to say, 'Hey, this program impacts on nursing. We need to take this into consideration; we need to have nursing representation here.'

CHAIR—We had somebody say to us yesterday that, given the current age, there would be nobody going into nursing who did not know how to turn on a computer. My suspicion is that a

lot of the people that would go into nursing would not have had access to computing much at all through their course.

Ms Iliffe—That is correct.

CHAIR—Could you briefly comment on the nursing IT needs for young people coming in? Then, as I hear it, so much of nursing work now is done by putting information onto the computer. When are staff released to get sufficient training time et cetera—to say nothing of what you are doing if you are working in the community and where you get your computer training there?

Ms Iliffe—I will make three brief comments and I might defer to Robyn to make a comment, because she is our educationalist. First, I think there needs to be better education for all nurses. There needs to be better access it, and this particularly applies in rural areas, where quite often the computer is locked up at night and the nurses do not get access to it. In remote areas you sometimes cannot get Internet access anyhow. So there are a range of issues. Some of the community nursing organisations are really excellent in providing their community nurses with information technology to take to the home so that they can do their documentation at the home and upload it so that it saves time, but that is the exception rather than the rule for those good ones.

Ms Parkes—On the undergraduate program, what we find with graduates coming through is that if they young the chances are high that they have had quite good computer access. Certainly in the university now they know how to use all of that to get the information they want and universities are becoming more user-friendly in the sense of providing student information rather than uni information, if that makes sense, by computer. However, it raises again the generational issue, that if about 30 per cent of your undergraduates are mature age the chances are their interaction with their computer is that their child at home uses the computer and they dust it; that is the kind of way we talk about it. Indeed, they are not allowed near it because they muck up the programs and so on.

What we have coming through into the hospital are two groups, but there is an assumption that because they have been through university they understand the Internet, they understand how to use the library resources and so on. One group finds anything about IT in hospital incredibly pedantic because it is relative to what they are used to out in the game based area, and the other group is terrified of it. Then you have long-term staff who are not used to it that we have had to educate on the way through. We have what we call internally a nervous Ned and Nellie class where the measure we use is people who pick up a mouse and use it like a remote control, or when the screen saver goes on they think everything has been lost and so on. That is the kind of criterion to get into this nervous Nellie class because it means you need assistance to work out what happens. So we have done some education from that level to tell people just which buttons to press to get the stuff on, but increasingly more and more software programs are coming in, and Royal Adelaide has two eight-seat training rooms and 5,000 staff. That is how we are try to work it at the moment.

CHAIR—I am interested in it too because of the points that I think you were making earlier, Ms Iliffe. It seems to me that as I listen to my medical colleagues there is a very significant amount of research and development for putting the whole of medical practice on computers.

General practice in some places is almost all computer driven. If a person is referred to a community nurse or leaves hospital with a discharge, in what way are the nurses out there able to match their computer up now? I think you said some might have Palm Pilots or laptops.

Ms Iliffe—Some of them do. There is a group of specialist professional nursing associations that meet on a biannual basis under the auspices of the Royal College of Nursing and the Australian Nursing Federation that have actually put a proposal together for an information technology centre for nurses where you might be able to provide the education that is needed and the recommendations about the sort of equipment that should be provided to nurses to make their work more efficient. If you like I can provide you with a copy of that proposal, because it goes to some of the questions that you are raising.

There is certainly a gross imbalance, as you can see from our submission, between the amount of money that is spent on medicine and the amount of money that is spent on nursing. We think that one of the reasons for that is because nursing has not been seen from a national perspective, and that is why we are so keen for the committee to make some recommendations about a national approach to nursing work force.

CHAIR—To what extent does the ANF have members in the universities now and to what extent is the ANF interested in, or even pushing, research?

Ms Iliffe—Is it possible to answer that?

Ms Thomas—Yes.

Ms Iliffe—Recruitment is a very big part of ANF's work in the university sector. They are our members of the future. We recruit there and we are quite heavily involved in university life. There is an initiative that is going on in South Australia at the moment—I have put Lee on the spot but she might want to share this with you—which shows our commitment. ANF is both an industrial and a professional organisation. We have a strong commitment to education and research.

Ms Thomas—Firstly, in relation to the students at university, we do have—and I am sorry that I cannot give you the exact numbers—many undergraduate students at university and also student enrolled nurses as part of our membership. In relation to the issue that you raise around research, the ANF in this state is currently approaching some of the universities and looking at a joint appointment between the university and the ANF at senior lecturer level. We actually see that as a very exciting and creative initiative on the issue of research. This person's role would be to advance our professional standing within the auspices of the profession. We are looking to appoint that person by the end of this financial year.

CHAIR—Unfortunately we have gone over time and we have to stop there. We stand adjourned until 1.30 p.m. Thank you all very much. If there is anything that you wanted to say and were not able to say, please feel free to contact us. We assume that if we need something we can contact you. Ms Iliffe is providing documents, which she requests to be tabled. They are accepted.

Proceedings suspended from 12.43 p.m. to 1.34 p.m.

BLACK, Mrs Julie, Member, Australian Council of Community Nursing Services Inc.

HEPPER, Mrs Denise Kim, South Australian Representative and Board Member, Australian College of Operating Room Nurses

NUGENT, Mrs Joy, Director, Founder and Principal Consultant, NurseLink

VAN LOON, Dr Antonia Margaretha, Director of Development, Australian Faith Community Nurses Association

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 we will give consideration to your request. I also need to remind you that the evidence given to a committee is protected by parliamentary privilege and that giving any false or misleading evidence may constitute a contempt of the Senate. I think that does not refer to inadvertent errors. The committee has before it your submissions Nos 747, 454, 787 and 335. Do you wish to make any alterations to your submissions? If not, I will ask each of you to make a brief opening statement and then field questions.

Mrs Hepper—This statement is made on behalf of the Australian College of Operating Room Nurses, a professional organisation that nationally represents all nurses working within the areas of anaesthetics, operating theatres and recovery rooms. The college, along with other nursing organisations, is concerned with the current nursing shortages both for health consumers and health professionals, especially in the areas of educational development and recruitment and retention strategies. ACORN remains committed to university based nursing courses but considers that there needs to be a review of the financial support for nurses undertaking postgraduate studies as well as adequate remuneration for earned qualifications. This, we believe, would encourage more specialist nurses to undertake further education.

We also believe that there should be more recognition of the contribution of hospital nursing staff to current university programs and a value placed upon this underpinning support. Undergraduate education, we believe, should contain more clinical exposure for students—with two varied specialty areas. There needs to be a recognition from universities of the diversity of nursing specialities today and the value of each and every one of them.

It is common to have a student relate that perioperative nursing has been described as 'non-nursing' by university based nurses. ACORN reinforces the need to support every clinician through the funding of more clinical education positions and the financial support for improved technological support for clinical education needs. Support of nursing staff, through focused orientation programs and ongoing clinical support, we believe will assist with recruitment and retention issues.

ACORN advocates the active promotion of nursing as a valued career option. Strategies to improve the culture and facilities within health institutions are recommended. Flexible rostering, maintaining adequate staffing levels and child-care provision in line with service needs—as well as supportive management teams—are essential in this consideration. Therefore

in our submission we have included discussions specifically in the areas of nursing education, recruitment and retention considerations and the promotion of nursing as a family friendly career.

Mrs Black—The Australian Council of Community Nursing Services is the national peak body representing all major and many smaller organisations providing community nursing services as well as individual registered nurses seeking to be members of a professional group dedicated to the advancement of community based care. It advocates for and on behalf of clients and communities and promotes standards and accreditation processes to ensure that quality outcomes are met for clients.

In our submission we have highlighted some key areas. Under ‘Nurse education and training to meet future labour force needs’, one of the issues we highlight is that, because of the tightness of community and aged care sector funding, there is a worrying imbalance of skill mix in the current work force and this has been evidenced by the reduced number of registered nurses who go into this sector. We ask that consideration be given to additional funding to support the progression, recruitment and retention of registered nurses within this sector.

Under ‘The interface between the universities and health care systems’, there are areas where there are opportunities for development, particularly working with universities to raise the profile of, and highlight the complexities for, people working within the community. We feel a major area is the retention and recruitment of registered and enrolled nurses in the aged care sector and regional areas. In particular, the funding of refresher and re-entry courses targeted at aged care and the funding of education for those working in rural and remote areas are issues that we feel quite strongly about.

Another key area is the wage parity between nurses in the acute sector and those working in residential aged care. There is quite a difference there. We also support the option to make nursing a more family friendly profession. We also consider it important to improve occupational health and safety and risk management.

Dr Van Loon—The Australian Faith Community Nurses Association is the peak professional body for registered nurses working in a faith community setting in Australia. A faith community might be a church congregation, faith based school, aged care facility or a community service conducted under the auspices of a faith based group. Our members are quite diverse—they work in schools, aged care facilities and sometimes just in congregational settings.

There are four key issues of concern to our membership. The first is postgraduate education. The needs of our members vary, and they are unable to have flexibility and choice within the postgraduate sector. They wish to take optional studies in a variety of other schools within universities, but there is not that flexibility within the tertiary system, let alone the opportunity to choose between universities across the country. They wish to tailor their studies once they are at postgraduate level to their particular needs and setting, and we would request that the committee give consideration to improving the flexibility and transferability of optional studies and postgraduate topics between universities, and, if not between universities, between schools within the one facility.

Our second key issue is the lip-service given to whole person care within our current system, educationally and organisationally. We believe that the medical model of health care is leading to an increased fragmentation of care, so much so that when you have eye surgery now you have someone looking at the retina and someone looking at the cornea. You cannot even have one person looking at a person's eye, let alone at a whole person. This is a significant problem for people who are trying to work in the community with whole people within the context of a home and community setting where they are unable to function properly.

We believe there needs to be much more consideration given in the accreditation process of organisations, as to how they implement their philosophy of care and how that is actually practised. We also believe there needs to be recognition and reward for individuals and organisations who are producing a valuing of the person. In fact, we believe that nursing is actually a litmus test for a much greater societal issue, and that is the devaluing of the person, and particularly the marginalisation of the frail, the elderly and those with chronic illness and mental health problems. Therefore, people who work in those professions are even more marginalised and their positions are not seen as prestigious. So we really think that there needs to be an addressing of the value-neutral education that has crept in over the last couple of decades, and we need to look at a stronger philosophical base for practice. We have people within our membership who we have specifically designated to go to Catholic universities so that they could have a value-full education, and they have ended up working in organisations which are value-neutral or value-free. This has caused a considerable problem for them—so much so that some of the newer graduates who are younger have decided that nursing just is not for them because the rhetoric does not match the reality.

Our fourth key issue is the public perception of nursing as a second-rate profession compared to every other health care profession that there is. We believe that there needs to be much more collaboration within the continuum of care and that government policy, and public health policy particularly, needs to look at increasing the autonomy of nurses as professionals in charge of their own area of practice. We believe that collaboration will be much more possible once we have a better understanding of how each professional contributes to the care of the individual. Those are the four key areas, and they have been addressed further in the submission that we made.

CHAIR—Thank you. Let us move to NurseLink.

Mrs Nugent—First of all, I would like to pay tribute to my tutor sisters. I come very much from the old school of nursing. Joan Godfrey and Barts Schultz from Brisbane were my tutor sisters, and they were very much involved with setting up the Royal College of Nursing, so I am a little bit different, I suppose, in what I have been doing and in what I want to say to you today. For the last 15 years I have been running a private nursing practice. Fifteen years ago everybody told me that this was something that you could not do. I have always said, 'Please let the marketplace be my judge.' So for 15 years I have cared for hundreds of dying people and elderly people in the community, without cost to any government organisation. It has been fee-for-service. I presently employ 44 carers and nurses to help me.

I am here today to really highlight the need for nurses like myself who would appreciate being able to set up a private practice like our fellow health professionals, who may be doctors, physiotherapists and dieticians. My background is that for 20 years I supported my husband's

orthodontic practice. I had management training and computer skills. I did my midwifery in Edinburgh and private-nursed in London. All of my background gave me a lot of skills that I see nurses not getting today. I run a practice that is very much patient driven. In that model I see that a lot of the things that are being taught today do not fit in. For example, I come out of a palliative care mode and there we talk about multidisciplinary teams. I find people in palliative care do not want to relate, when they are dying and terribly vulnerable, to a whole lot of people. They want that patient-nurse relationship. They want the nurse—I did this the other night—to get up at 2.30 in the morning when they are having a panic attack and have that continuity. I see nursing as being very fragmented. What happens with the community dollar at the moment in nursing is that there is an hour here and an hour there. People do not know who is coming. I think that nurses have lost that opportunity to have a therapeutic relationship with their patient. This can happen only if we look at holistic care and see that a patient has physical needs, intellectual needs, emotional needs and, above all, spiritual needs. We need to have that humanistic approach of being there as whole, healthy people for them. That comes down to time restraints.

I think there is an enormous amount of satisfaction to be gained for nurses who want to set up in private practice, as I have done for the last 15 years. The lessons from my struggle I would like to pass on so that others do not have that struggle. We have the most incredibly up-to-date computer system that supports all our records and financing. We have the ISO 9000 accredited training manuals so that they can set up an office and know exactly how to do it. What I am working on at the moment are training manuals so that they can train their staff.

I have found that the marketplace will not pay for nurses if they can have a carer. What we need is for the nurse to be a coordinator of the case, the one that supervises the carers. My carers come from all walks of life. A lot of them are retired professional women whose families have gone and they want to make a contribution. I do not believe that we should get hung up in level 3, level 2, level what have you, training. We must recognise life skills. I really think that is all I have to say.

Senator WEST—There seems to be, amongst at least a couple of you, an issue with undergraduate clinical experience. I think at least two of the groups have said that there is a need for more undergraduate clinical experience. We have had evidence from other witnesses, not necessarily here but in other places, that the places available for undergraduate clinical experience are getting more and more stretched. How would you anticipate overcoming this problem or how do you anticipate giving more clinical experience, recognising that you are both in specialty areas of course?

Mrs Hepper—We have the facilities to provide more if asked. We are not asked.

CHAIR—You have the facilities to?

Mrs Hepper—We have the facilities to provide for more undergraduate students, but they are not requested to be placed in our area.

Senator WEST—In theatre.

Mrs Hepper—In theatre.

Senator WEST—What about in the community?

Mrs Black—Certainly in the community we do take a lot of undergraduates on placement. But it gets down to the fact that the workloads of registered nurses are ever increasing and we are actually asking them to take on an extra workload. Each of our members takes pride in making sure that when you have got an undergraduate student you do give them the right experience. There needs to be funding available to be able to have extra staffing and to be able to support nurses in the community. It is very different from the acute sector where you can have support from the university walking around different wards. When you have 300 nurses on the road every day, as we do in Adelaide, it is very difficult to do that supervision. We have designated education units that we work with, but we are very limited in the number of students we can take because we just cannot take that extra workload on. I think particularly community nursing is something that we are just not giving our undergraduates the opportunity to explore because there are just not enough places to take them.

Senator WEST—Does this mean that they need to spend more time as undergraduates studying? I was an old, four-year hospital based trained nurse, who reckoned that three years were never good enough because they did not spend as much time in the wards as we did. Is there a need for increased time spent in training?

Mrs Black—I think there would be a good opportunity to actually increase the community placement time. The universities would argue, I guess, to try everything else in that you have got to. It can be difficult, but certainly I think there are wonderful opportunities. Because the students are not getting that experience in their undergraduate study, it is often not an option they can explore once they are registered—and they will automatically go into the acute sector. So it is something we should be promoting and supporting more.

Senator WEST—Does the same apply to OT?

Mrs Hepper—I think the clinical areas that they are exposed to and they enjoy they are attracted to. Those clinical areas that they do not get to experience they do not consider. So those who do not come to theatre would not consider it a career opportunity.

Senator WEST—Does every student get to at least spend time in theatre?

Mrs Hepper—No. They get to choose their placements, as I understand it. A lot choose ICU because it is a glamour area, and a lot of those glamour areas attract the nurses these days. The less glamour areas—and community is probably one of those—do not attract them.

Senator WEST—Community and aged care?

Mrs Hepper—Yes. They do not attract them. I come from hospital training as well, and we experienced everything before we chose where we would specialise.

Senator KNOWLES—Can I clarify that. You say that no-one asks specifically to go to the operating theatre, but I would have thought—pardon the pun—that that is the cutting edge of medicine in many areas. I would have thought, ‘Hey, that is a status thing that you are a theatre nurse.’

Mrs Hepper—No.

Senator KNOWLES—Why?

Mrs Hepper—Theatre has a lot of historical background that it bears, if you like. It is seen as an environment—and excuse the language—that is full of very strong women who are bitches, and you are the doctor's handmaiden and told what to do all the time.

CHAIR—That is a fantastic double act—to be a lady dog and a handmaiden all at once. That is talent!

Mrs Hepper—It is very technical, so you cannot actually do nursing. Those things are historical baggage that people carry around with them, and if you are a senior nurse and an educator and have had a bad time in theatre it is not somewhere that you will encourage your nurses to go.

Dr Van Loon—I do not think it is as much the quantity of clinical experience that is the problem as the quality of it. Putting someone in a place does not necessarily make a learning experience. Sometimes the learning experiences that they have, if anything, send them as quickly out of the door of nursing as possible because they have had very poor experiences. It is not just a matter of exposure; it is a matter of quality learning that goes on within that place with the support that was mentioned before by Julie. If people do not have any learning support, they are not going to learn anything that is going to actually make them want to stay in nursing.

Senator WEST—So you hear of differences in the standard of clinical placements?

Dr Van Loon—Absolutely.

Senator WEST—We have had this evidence on other occasions. What does your institution do to say, 'Hey, these people are not getting their clinical experience,' or, 'This is a good clinical placement, that is a bad clinical placement'? What is the profession doing to make sure that the universities are using only good clinical placements and to have input into upkeep? I think the Nurses Registration Board is behind us, so they can be prepared for some of these questions too. What is happening to ensure that appropriate clinical placements and appropriate standards are being observed in those placements?

Dr Van Loon—Most of our membership are already registered, so all I can feed you back is their experiences as they went through, and some went through hospital based courses and some have been more recent graduates. One of the key reasons that the recent graduates come into this organisation—and I should add that most of our membership work in a voluntary capacity—is that they are able to provide the care that they have always gone into nursing to do. They went into nursing with a set of values that were their own; they were not necessarily always endorsed in the curriculums that they went through, but they have managed in some way to work through how they can practise them on a patient-to-nurse relationship level. They work their way around making the system work for them. If they cannot, they end up doing this kind of nursing within the Faith community. That is because they do not have the time constraints and all the problems that are attached to working in an organisation in which, while you are given a whole set of skills in counselling and those types of interpersonal communication skills

and so on when you go through the curriculum, you never have the time to put any of that into practice. You do not even have half an hour to sit with anybody. That is what I hear over and again from people. In this position, even if it is in a voluntary capacity, they have some time to do some good.

Mrs Black—We work very closely with the universities and with the clinical placement areas. They hold a forum every year and get on board all the key stakeholders that have been involved in clinical placements for students. The other key to success with undergraduate clinical placements is evaluation. Certainly there are competencies that they have to reach as part of their clinical placement. I feel quite confident that the students who are coming through today would speak up if there were a placement they were not happy about. The key is organisations evaluating themselves, along with the universities, what they are doing on those clinical placements.

Senator WEST—How has the practice of community nursing changed over the last 25 or even 10 years?

Mrs Black—I think it has changed even over the last five years. If we look at early discharge from hospitals, there are now far more people in the community with very high needs that we did not see before. I am the director of education within RDNS and I look at the skills our community nurses have to have and at what level; certainly, with people choosing to die at home under palliative care and the set-up in some homes—and Joy would be able to reinforce that—it is like running a mini hospital. It is getting more and more complex, and this is where education for registered nurses is essential to keep up to date—just with the equipment and so on that they have to deal with. The other issue that we hear about from our members, whether they are in aged care or working out in the community, is the level of documentation that you have to have to get your funding. It is becoming overwhelming. The two major changes in recent years are the level of expertise that we are requiring our nurses to have and the level of documentation. You hear a lot of them say, 'I went into nursing to care for people but I am spending a lot of my time doing the paperwork that I have to do.' They are the two key issues.

Senator WEST—What is happening to the primary and preventive care role of community nurses?

Mrs Black—That is all part of looking at every client with a holistic approach, looking not just at what is wrong with person and why have they a leg ulcer, and treating the leg ulcer, but at what is causing it. When our nurses go into homes they will often look in the fridge, because nutrition could be the reason why that person's leg is not healing. Within the aged care sector that whole area of primary health care and prevention is a key role in nursing today.

Senator WEST—I know it is a key role; I recognise that. I freely admit that I have a bias towards community health. But are shorter hospital stays, quicker discharges and the higher level of acuity of patients in the home swinging the balance so that the amount of nursing care being given is shifting away from the primary role and more to an extension of the secondary and tertiary roles, so that you are not finding as much time to run, say, a whole program about asthma or diabetes, or the sorts of programs that you might have been running as group things?

Mrs Black—I think we are still taking that on. Certainly a lot of organisations are developing clinical pathways so that the whole management of a client's disease—whether it be asthma or diabetes—is mapped out, so that it is not just done in a hotchpotch way; it is done in quite a co-ordinated way. That is happening throughout the community and certainly in aged care so that things are not being forgotten.

Senator WEST—What about occupational health and safety?

Mrs Black—From the perspective of larger organisations, particularly for organisations such as Blue Care and RDNS in Victoria and RDNS in South Australia, where you are going into people's homes, occupational health and safety is a real issue. There are very good programs in place, and I am quite confident that organisations put that as a high priority and work towards that. In relation to smaller organisations, I think it is something that they are aware of but it is an extra thing. Everybody is aware of the issues of occupational health and safety, but there could be—like anything—more time to go into it.

Senator WEST—What about the issue of backs—as someone who sits here with a sore back?

Mrs Black—Most organisations have no-lift policies now. They have quite extensive training in manu-tension as part of the accreditation process and WorkCover and all of those things. They are the things that I wish we had 20 years ago—we are all probably sitting here with bad backs from when we used to heave people up the bed.

CHAIR—How does that happen in community nursing—if you are out with an early discharge patient post-surgery and there is a no-lift policy?

Mrs Black—They have this most magnificent thing—a 'slippery Sam'—and it slides people up the bed. I have heard furniture removalists now have them for moving furniture. So, out in the community, nurses do not lift at all.

CHAIR—That is sides. Does that turn?

Mrs Black—It turns—it's marvellous. It is like parachute material.

Senator KNOWLES—As long as they slide up the bed!

Mrs Black—One of the biggest issues with occupational health and safety we see is our nurses can get in and out of the car 30 to 35 times in a seven- or eight-hour shift. That is where we see the occupational health and safety issues—the way they twist and turn getting in. We very rarely have back injuries because of the no-lift policy has been introduced.

Senator WEST—How often would cars get broken into on the suspicion that, because they are carrying equipment, they might be carrying drugs?

Mrs Black—I do not have an answer for that. In the two years that I have been with RDNS, at management meetings I have not heard of cars being broken into for that. Most of the time, they just carry dressings and that sort of thing.

Dr Van Loon—You mentioned earlier the differences between now and 10 or 15 years ago in the community. One of the things that I think has really shifted is the funding towards preventative health and towards health promotion. Even the policy speak is different: when you look at 10 years ago, policy was speaking about stakeholders, that a stakeholder has an interest and an active interest in it; now the policy talks about consumers, and a consumer is someone who devours a resource. The whole shift in speak has changed, and so has the emphasis into continuation of medical care into the community, rather than actual health promotion.

It is very hard to put an outcome base on something you prevent. A lot of the work that our nurses are doing is actually preventing and building community and building social capital, which are all the precursors for good community health. None of that is actually funded and it is never in any of the policy speak, because all of the health promotion type work has moved into care of chronic diseases and disease management in the community. That is where the shift has gone—and it still goes under the same name of community health, but it is actually community medicine; it is not community health at all.

Senator WEST—RDNS, do you have mental health teams as well?

Mrs Black—We have one staff member, our mental health nurse, to do the whole of the metropolitan area, and it is very hard work. It is a troubleshooting position: where there is a problem with someone with a mental health illness, this one clinical nurse consultant will go and support the management plan—that is a whole area—particularly with the number of clients we are seeing now in the community with mental health problems. It is like anything: unless it is funded, it is very difficult to find the funds to create positions; but there is certainly a huge need out there.

Senator WEST—So what happens to those with a mental illness who have a multiple disease situation? Do you handle them or does the mental health team handle them or do you both try to handle them?

Mrs Black—This is where communication is really important—it would depend. Within the RDNS in South Australia, if there is a problem where someone may be violent, we have a coding system where two nurses would go, and we try to make sure that one is a male registered nurse. So we have safe systems in place to alert us to the fact that someone is going to be violent—if that is the issue. All our staff are trained in the management of people with all health problems, but if they need that extra support we have one registered nurse that we can work with or we call in the mental health teams if we need to.

CHAIR—Do you actually have an arrangement with the police force for dealing with psychiatric patients?

Mrs Black—We have an arrangement with the police force where we can check to see if someone is a problem. For instance, we may have people that have been discharged from jail

with a gunshot wound, which was a case a couple of years ago. If they were mobile enough, we would see them in our nursing centres rather than go into the home.

CHAIR—'Discharged from jail with a gunshot wound'?

Mrs Black—Sorry, someone who had been in jail who had a gunshot wound that had not healed. I do not know the full story. We do have a lot of former prisoners that have wounds that have not healed that our nurses see. The good thing is that we have now set up a system—and it has only been in for the last six months—where we can do police checks on clients that we are worried about. We can refuse to see them if we think the nurse will be in danger.

CHAIR—I am interested because of the reportage in recent times of fatal accidents, when police have attended psychiatric patients and those patients have finished up very dead. My recollection is that it is more than likely to be on Bondi Beach than in South Australia—

Senator WEST—No, in Victoria too.

CHAIR—Is that because there is an arrangement in South Australia where the management of such people is better handled?

Mrs Black—Certainly within our organisation—and that is all I can speak for—it is all about communicating. If a nurse feels at any time that they are in a dangerous situation, they are taught to get out and not to stay within a house. We have security cameras in our nursing centres so we can actually see who is in the waiting room and we have hazard alerts that the nurses can press. We have all the systems to try and ensure that our nurses are safe at all times.

CHAIR—I guess there are different situations and you cannot extrapolate, but one of the things that certainly seems to be said—and, in my experience, it is the case—is that the changed nursing capacity in mental health areas has made such a difference to patient outcomes and that nurses have learned to be with psychiatric patients, when they are up and when they are down, and that that recognition of the danger signs has made the difference.

Mrs Black—We try to have consistency so that the same nurse will do the same round each day, so they get to know their clients and they can pick up early warning signs rather than wait for something to explode.

Senator WEST—This will be my last question, and I would like to bring Ms Nugent into the discussion. What has the impact been on those who are providing care—in the community in particular—of the expansion of community aged care packages and HACC programs and the consequent increasing use of unqualified workers under the supervision of RNs? How do you ensure that the standard of care is appropriate and how do you provide support to your RNs in the delivery of that care?

Mrs Nugent—I will speak from my experience. You asked what is best for undergraduates. I believe that mentoring is one of the best ways to go and I think what has happened is a pity. Even in my private practice, I have been asked to take students and I did that until a few years ago. It is very difficult when people are paying me privately to do that. However, over the last 15 years I have employed an enormous number of students. I put them in placement, sleeping

overnight with a dementia lady or whatever, but they are under my supervision. I believe my role as a nurse is very much one of education. You talk about preventative health. People pay for my service, some of them up to $3,000 a week, and it goes on for years, so they are not going to pay for something they do not value and they are not going to pay if they do not really want it. Part of my role is to teach the family ways to care for themselves and for me to only be available by phone. They have a 24-hour-a-day service. That is very much part of my role.

These community packages, as you say, use very much the same case management and case coordination models as I do. What I see more and more is that the package will supply so much and then families will ask me to fill in the gaps. A package will pay for an hour, so I will go in and do another two or three hours while the dementia respite husband, who pays me, goes and plays golf. I think we as a society need to encourage more of a user-pays approach, rather than the government having to provide and having packages. I think we should be open to saying, 'A package will provide this. We can only give a limited amount of supervision.' It does not mean you do not do it, but I think we have to make provision for other people to come in and pay if that fills their want or need, however you want to describe it.

Dr Van Loon—I think we actually pick up the other end of the spectrum—

Senator WEST—I was going to say there are not too many who can afford $3,000 a week.

Dr Van Loon—those who cannot afford anything. We end up being a gap service in many ways. One of the things that we are not trying to be is district nurses for free, or home nurses or palliative care nurses or any other form of home nursing. The bulk of what we do is actually in the area of health promotion and illness prevention. However, we find that we do lots of resource referrals. Not many people know what resources are actually out there. Even though there is a plethora of pamphlets around in every doctors surgery and community health centre, most people have no idea how to go about finding the adequate care for their ageing relatives or the resources that they need.

We very much provide a gap service there because we often find that people's payments have finished. I can give you a quick example of one woman whose payments for physiotherapy had ceased. She had chronic lung disease and had had four admissions to Queen Elizabeth Hospital in the prior year. The nurse in her parish of a Catholic church in the western suburbs took her on and educated her husband on how to do her physiotherapy and her care. He was very anxious initially and it took about two months of regular 15-minute visits a couple of times a week with her there. Eventually she pulled out and he took over. The best part of this story is that this woman had no hospital admissions for the 12 months afterwards. She actually went on a holiday interstate, which was the first time she had ever done that, and the support systems were put in place because her husband was actually educated in that regard. They bought a cheap stethoscope so she was able to listen to her own chest and know when she needed to go to the doctor to get the oral antibiotics so she did not need to be admitted.

It is this kind of care that the system cannot do, but there is no mechanism for these people to find funding to extend their services either. Funding for more innovative programs needs to be made available from a government level, because there is no opportunity, if you are new on the scene, to even get seeding funding for this kind of program.

Mrs Nugent—What I would like to add there is that I see so many really wealthy people—because that is my end of nursing care—who can pay for their own care, but the moment they get a whiff of a package or what have you, and because they have got connections, they tend to get them before people who really need them. I know this comes back to those nasty words ‘means test’, but I can tell you that there are some incredibly wealthy people who could well afford to pay for their own care, which surely would free up funds for more needy projects.

Senator KNOWLES—I would like to compliment you, Mrs Nugent, on your submission. I think it is a fantastic submission; it goes right through a whole range of things, to say nothing of your own personal CV—it takes one longer to read your CV than it does to read the submission almost. I will just come to my question: did you say that you have 44 staff?

Mrs Nugent—Yes, 44 at the moment.

Senator KNOWLES—Are they full-time staff?

Mrs Nugent—No, they are all casually employed, because I have to run a caring service without funding.

Senator KNOWLES—That is right.

Mrs Nugent—And I have to respond on a needs basis. I suppose I started off being all things to all people and trying to, as Mrs Black will realise, support all nurses who wanted to do private practice, whether it was continence, palliative care or what have you. I would help them with admin and take an admin fee for that.

Since then, and probably since the submission, what I have done is refine the model to a single unit so that it is basically my unit. Yes, I employ 44 people and they are all casual. There are probably only about five nurses, and the rest of them are carers in whatever capacity, but they are highly educated. It is a unit that stands alone and is self-sufficient. I do not know what else to say, except that it works.

Senator KNOWLES—When I say full time, I do not mean that they turn up at 9 o’clock and leave at 5 o’clock. What I really mean by that is: are you utilising 44 people generally all of the time?

Mrs Nugent—Yes, all of the time. Some of them will do maybe four hours a week and some of them might do 50 hours a week, but they are all being utilised. I tend to keep that band because it is a good number. I know them all and I can control the situation. I tend not to take on a new patient if I have not got the appropriate people. So it is always chicken and egg. That way I have made sure that the model stays cost-effective.

I cannot help thinking that if half the little models that are out there, even with RDNS, were little practices and were cost-effective and people could afford to pay for their care we could still have that. That would free up a lot of funds for really needy people, because it is often the squeaky wheel that knows how to get the funds that gets them.

Senator KNOWLES—What would nurses and carers earn through your organisation vis-à-vis alternatives?

Mrs Nugent—I pay a nurse $20 an hour and I pay a carer $13 an hour. I employ them, I pay their superannuation, I pay their WorkCover and I pay their professional indemnity public liability insurance. It is a flat rate.

CHAIR—What does a 'nurse' mean in this context?

Mrs Nugent—A registered nurse. An enrolled nurse gets $15 an hour.

Senator KNOWLES—What do they get in general community nursing?

Mrs Black—It depends on what year level they are at.

Mrs Nugent—NurseLink has a flat rate. It is the same rate 24 hours a day, seven days a week, and on public holidays. There has always been this policy that people do not stop needing you just because it is the weekend. So we have tended to be patient driven. I honestly do not know what they make, but I know that people like working—

Mrs Black—I think it is about $38,000 a year or something like that.

Senator KNOWLES—Mrs Nugent, are there various other organisations such as NurseLink in other states?

Mrs Nugent—Not that I am aware of.

Senator KNOWLES—Why would your model not have been snapped up by other energetic people?

Mrs Nugent—It is about to be.

Senator KNOWLES—Is that right?

Mrs Nugent—I hope so. I have been working on it and refining it. We are about to franchise. I have been tidying up all of the documentation, the procedures and the policies. Everything has been written down, in absolutely every area, whether it is personnel or admin. These are the final chapters. That is with the graphic designer and publisher at the moment. Our portfolio, which is patient held documentation, is written on nursing diagnosis and talks about preventative health—you might like to look at this—activities, for example, looking at how you sleep and rest. How do you like it? Do you like the curtains drawn? Do you like two pillows? Let us write it down. Are there any of these things that would help you?

This whole portfolio is designed to basically help people care for themselves. We are just there to fill in the gaps. When it comes to occupational health and safety, we have a safety checklist in the back of it so that everybody can be aware. But I am also aware, in terms of occupational health and safety, that we are guests in patients' houses and they may have, for ex-

ample, a Persian carpet that they have stepped over for 20 or 30 years and, while we may see it as a hazard, they do not. Their unconscious self picks their feet up. So it is not a simple thing of having rules and regulations. This whole model is to help people to care for themselves. Sure, we are fee-for-service, but we will fill in the gaps. So, very shortly, we are about to pull all this together and go on a national selling campaign.

Senator KNOWLES—How do you find time to care for yourself?

Mrs Nugent—Well, I have four children and five grandchildren.

Senator KNOWLES—You have had one more grandchild since the submission.

Mrs Nugent—Yes, I have. I also consult in Malaysia, so I am up there twice a year.

Senator KNOWLES—Good heavens.

CHAIR—As I understand your submission, the last page before your CV, you point out to us:

Superannuation, PAYG tax deductions and WorkCover are not administered ...

Mrs Nugent—That was when nurses were self-employed. As you know with the new tax laws, the government does not like contractors. So it is too hard because the computer system that takes off the administration fee I have to add GST to. It is all just too hard. So that part is no longer true—and I will give you an updated copy of that.

CHAIR—I thought you said differently and I just wanted to check that.

Mrs Nugent—I now take that whole responsibility, mainly because of GST. GST created a whole rethink. It is too hard to do that anymore.

CHAIR—Thank you.

Senator KNOWLES—I found that incredibly interesting. I am sure that I will think of many more questions when I get on the plane tonight. If I can come back to discussing operating room nurses, an alarm bell that is ringing with me from what you are saying is that sooner or later, unless we do something positive to encourage people to experience the operating room lifestyle, theoretically we will run out of operating room nurses because people are not getting exposure to it.

Mrs Hepper—Or they will be replaced by other level workers.

Senator KNOWLES—That is not necessarily the most satisfactory solution that one could dream of. So we have to look at how on earth we get people to have a positive experience, whereby they will take that up as an option of specialty.

Mrs Hepper—We cannot guarantee a positive experience but, if the opportunity is there for them to experience, there will hopefully be a greater number of nurses choosing to come into the specialty.

Senator KNOWLES—We have heard so much during this inquiry about bullying and about the beasts, to whom you might have referred earlier.

Senator WEST—Nurses have even been accused of eating their young!

Senator KNOWLES—Do you think there is a greater prevalence of those sorts of occasions in theatre than there would be on the wards?

Mrs Hepper—Today, no. We have more structured educational programs than we have ever had. When I trained you were dropped in at the deep end and you had to sink or swim. These days, we have a lot more orientation that occurs before our undergraduates or our junior staff enter into the area and become truly active in the specialty. They are given a lot more support than they ever used to be.

Senator KNOWLES—You say in your submission that nurses should be remunerated for the specialty. While some states have adopted this practice, not all registered nurses are recognised per se. What is the difference that you are aware of between the states?

Mrs Hepper—I think that part of the submission relates to the operating room certificate, or graduate diploma as it is now, which is not remunerated for.

Senator KNOWLES—When you say that some states have adopted this practice, is there another model that you could point us to?

Mrs Hepper—I cannot comment on that. I was not the initiator of the submission. I could provide you with that information.

CHAIR—On page 5 of your submission, under the heading ‘Financial incentives’, you state:

Greater incentives for being ‘in-charge’ of a shift should be in place. Currently nurses in New South Wales receive $15 per shift.

Mrs Hepper—As I said, I cannot comment on that at this stage. I would have to find out that information for you.

CHAIR—If there is anything further that you can offer to the committee or in answer to Senator Knowles’s question, that would be very helpful.

Senator KNOWLES—Page 5 does not really go to the core of what I am getting at because I am looking more particularly for the type of remuneration you would seek for those who are qualified in that specialty, and the other incentives—that is, you have listed here study leave entitlement as well. How long would you look at study leave entitlement and on what basis—full pay, part pay or whatever?

Mrs Hepper—Again, I am sorry I cannot comment on that. I am not the initiator of this document. I cannot refer to what was in her mind when it was put together.

Senator KNOWLES—I understand that.

Mrs Hepper—I would certainly suggest that, even if it is not paid leave, it is leave without pay to attend lectures et cetera. That does not always get support these days in some institutions. As to the remuneration, I think firstly it would be a recognition of the speciality education, whether it is a certificate or a grad. dip. That would be the first step that would be referred to here: to be recognised as useful and be paid according to other certificates which are recognised and paid at this point in time.

Senator KNOWLES—Which ones are recognised and which are not?

Mrs Hepper—Midwifery is recognised.

Dr Van Loon—Mental health.

Senator KNOWLES—ICU?

Mrs Hepper—No, I do not think so.

Senator KNOWLES—IC and CC are not recognised, are they?

Mrs Hepper—I do not think so, no. We are requesting our staff to go after higher education—but why should they? If they do not get paid for it and they put in a lot of money to actually achieve it—attending a lot of education after hours but they do not get paid for it—then you are not going to get people to do it.

Senator KNOWLES—Not only that; in some cases they actually get paid less at the end of the day, don't they, because if they take a charge role then they are not getting the allowances or overtime or whatever?

Mrs Hepper—Yes.

Senator KNOWLES—I want to come back to this question of exposure to the clinical environment by undergraduates. Given that people are not asking for it, maybe there is a responsibility to go out and seek it. Do you know whether that has been attempted?

Mrs Hepper—To my knowledge, ACORN, the college, does have its representatives in each state go to open days. We have a lot of our higher echelon members, if you like, who are educators in that state who actively seek the support from the universities.

Senator KNOWLES—People experience emergency in their undergraduate clinical experience, don't they?

Mrs Hepper—Some; not all.

Senator KNOWLES—But they can do it?

Mrs Hepper—They can do any area, but it depends on which area has a focus with that university, who your lecturer is, as to where they see nursing and non-nursing.

Senator KNOWLES—And what their experience is, presumably.

Mrs Hepper—Yes.

CHAIR—A number of you—perhaps not Mrs Nugent but Mrs Hepper certainly—would like to see the abolition of HECS. Mrs Hepper recommends that the undergraduate courses should be HECS free. Can you please explain what is meant? I am having trouble understanding. I thought we fought for years and years to get HECS so that people did not have to pay fees. What is meant by 'HECS exempt'?

Mrs Black—When most of us trained you were paid and it was like an apprenticeship whereas nowadays, with nursing now in the universities, at the end of a course they will come out with a HECS bill like most other professions that they will have to pay off once they start generating an income. We were coming from that perspective.

CHAIR—I suggest that we need to be specific about that, because sometimes I have understood 'HECS exempt' to mean that you had to pay up-front fees. That is one of the problems. Some of the postgraduate courses would be much better if they were covered by HECS so that people could pay them off. Sometimes that is referred to as HECS exempt. I am not sure whether you mean that you want undergraduate students to have no fees at all.

Mrs Black—I am in the same boat as Mrs Hepper: I did not write the submission. But my understanding was that, to make the course more attractive, it would be exempt.

CHAIR—Is that called an ambit claim—the only profession that does not have to pay? It is a bit ambitious.

Mrs Nugent—We should all be the same. We should be the same as physios and doctors et cetera. It is time for nurses to grow up and be like everyone else. The people who do my courses pay for their courses. Why should we have to provide education as we did? I think it is time that nurses were accountable for their education. That does not mean that they do not need a good income, they do, but maybe there are different ways of earning that income and being more accountable and responsible.

Mrs Black—Can I clarify something. I have just reread the submission. It is postgraduate programs we are talking about and they do have to pay a fee up front. To address that in South Australia, within RDNS, we have actually looked at payroll deductions to support our registered nurses to do post-basic training so that they do not have to pay up front.

Dr Van Loon—I think remuneration for the qualification is more the issue, rather than fee paying. If people are going to the trouble of getting an education in oncology or palliative care or whatever and are going to fund that themselves, then there should be some incentive at least for salary recognition, which there is not in the majority of the qualifications. I would hate to

see nursing at undergraduate level become HECS exempt as a way of resolving recruitment. That would just tip in a whole load of people who may not actually want to be nurses at all, but it does not cost them anything to get the qualification. I think that would be such a retrograde step that it should not even enter our heads.

Senator KNOWLES—I meant to ask a question about the Faith Community Nurses Association. I must admit I have never heard the name before. Does that include church hospitals?

Dr Van Loon—Some of our membership are working in church based hospitals, but the focus is pretty much on people working in the community under the auspices of a faith community. It is known in the US as parish nursing, and there are numbers of people who are funded to work by hospitals in the US. Their whole system is different from ours, so it has not worked here, although I believe that the Sydney Adventist Hospital is looking at a program based out of the hospital and into the community. The focus is very much on the community and community health rather than community nursing. You probably have not heard a lot about the organisation because it is fairly new. It has only been around since 1997.

CHAIR—I think I understand the language about HECS, but I would like to be clear. Submissions that suggest undergraduate nursing should be fee free are not what you are proposing?

Mrs Black—No, it is postgraduate nursing.

CHAIR—That is because a lot of people who would like to do postgraduate courses have to find the up-front fees. So what you want is for them to be covered by HECS?

Mrs Black—The other thing that we are proposing is that there should be more nursing scholarships available, particularly in aged care and community nursing, because at the moment there are very few around.

CHAIR—I appreciate that. So postgraduate courses need either scholarships or to come under HECS so that people do not have to find fairly significant up-front fees, particularly when there is no financial recognition after they have completed the course.

Mrs Black—That is true.

Dr Van Loon—We also want the opportunity to pick and choose units from other places. There is no transportability currently. You buy a package and, if the package is not actually what you want, you cannot pick optional studies—even out of the schools in some universities. It is incredibly frustrating when you are paying the fees for a course and you cannot find something, but you could cobble together pieces from other disciplines to create exactly what you need to educate yourself for your own benefit. As a mature age student, that is an incredibly frustrating exercise.

CHAIR—Can you give us an example?

Dr Van Loon—There are units run by the Australian Catholic University in Sydney on pastoral care, grief and loss, spirituality and ageing. A variety of different universities and accredited higher education organisations run these kinds of units. If I am doing a graduate diploma in community nursing and I want the core units in nursing but would like to choose my specialty units in pastoral care and grief and loss management because that is going to be the focus of my work, I cannot do that. I have to take a course from, say, Flinders University which might be something completely useless to my area of practice. In some ways I am an advocate of the voucher system where you are able to purchase the topics or the courses that you want from another organisation. But you cannot even do it within the university—outside the school—let alone across the country.

CHAIR—Dr Van Loon, who have you raised this with to try to change the system?

Dr Van Loon—We put a submission in to several of the universities, but they say there is no possibility under the way universities are funded now, because they would lose their funding. If they allow you to take up topics from another school, that school loses its funding. It is just not viable for them to run courses where they lose half their funding because you have to pay it to another school.

CHAIR—Whom should we talk to to find out more about that?

Dr Van Loon—I do not know.

Mrs Nugent—Sometimes we need to have a paradigm shift in the way we think. I lived in America for three years with a husband who was doing postgraduate work. Under the American system—and I am not saying it is right or wrong—you got a bank loan and paid for your education, and then you went out and did things. It is not so easy, and nursing is predominantly women. We have not thought about getting bank loans and being businesslike, and I do not think nurses have thought about being businesslike. But if we are going to make our way with every other profession, maybe we need to have within the universities and within the education system ways in which people can use finance management so that, if you want a career in a particular way and it will cost such and such to get that career, this is how you can do it: you can take out a bank loan. What I am trying to say is that it does not always have to be government funded.

CHAIR—Thank you, Mrs Nugent. Even if it is government funded, it does not always have to be dull. We have had other evidence given to us of pushes to get the courses to be more reflective of what nurses need. Dr Van Loon, you are raising an issue. Do you know of other people in nursing who have the same kind of requirement as the one you are raising?

Dr Van Loon—At postgraduate level, it is probably an issue for many people who would really like to be able to tailor their optional studies for their postgraduate degree to what they need. That flexibility is just not available within the current system.

CHAIR—It is a very interesting point. We might have the opportunity to put that to some of our nurse educators after today. Mrs Black, I was extremely interested to hear that sometimes, as a nurse in a house, you might open the refrigerator and discover that somebody is not eating well. Senator West recalls when she was at school studying to be a nurse. I remember when the

winds of change blew through RDNS, and nurses were only allowed to do nursing duties and other people were employed to look in refrigerators. Do you remember those days? You probably do not—half your luck!

Mrs Black—I was probably working at the children's hospital then. They were well fed.

CHAIR—Some kind people down the back are suggesting that I did not make that up. I think it is really interesting. Has community nursing gone back to a somewhat more holistic approach, looking at how people's houses are set up, how their lifestyle is and so on?

Mrs Black—Certainly, in South Australia, we have embraced the whole issue of primary health care. We now have a client needs assessment tool that we fill out on admission that looks at every part of a person, not just the wound that has gone in to be treated. It has been slow to have uptake. It has met with resistance, because it takes a lot of time to work through. But it looks at the whole person and not just the wound you have gone in to treat, and I think that is an essential part of nursing.

Dr Van Loon—One of the things that I think is happening though is that, whilst educationally there is that rhetoric, I do not know that that is actually translating into reality and practice. I think that that is the same when you have students going into hospitals. We have what we call the ideal nursing picture and then we have the reality, and the reality often does not in fact match up to what the ideal is. I think that is a source of frustration for the community and certainly for our membership. The dominant reason that they get there is the frustration, because of all the constraints, of not being able to translate the picture of what they really see nursing to be into reality. Those are sometimes interpersonal—the dynamics within the health team. I hate to call it a team because I don't even think that a thing such as a health team exists in the acute care setting; it is a whole lot of disciplines that may now and again have a case conference but, by and large, there is very little communication between the disciplines in our health sector.

These nurses are so frustrated that they are unable to provide what they really see as quality care—and I think that that word 'quality' and also dignity are so manifestly abused in our discussions on health care now because they have vastly different meanings to different people. Some people see quality as only looking after the wound and some people would see it as looking after the whole person. Sometimes the rhetoric says 'looking after the whole person' but the reality is they have 15 minutes to do it and have not got time. So there are a whole lot of issues there about what we see as ideal and what we actually experience as real, being quite incongruous at times.

CHAIR—Do you have a sense that what your membership prefers by way of good nursing is more available in community health than within, for instance, institutional care?

Dr Van Loon—Yes and no. Timewise in the community: because most of our membership are not paid, they have time. But I actually think that there is an interface between a nurse and a patient that is really at risk now with the current rapid flowthrough in the acute care setting; it is in that interface that caring for the whole person occurs. What I see—I am not wearing my AFCNA hat here; I also work in the hospital and in the university—in reality in the clinical area is a lot of nurses going into the patient area, doing what they need to for the patients that they have and going out again. It is an 'in and out, do the physical care situation' and there is really

no active interest in going any further. Sometimes it is a time factor; other times it is actually a choice to not be involved. I think that sometimes we hide behind the fact that there is no time, but really it is a choice that nurses have made to not get involved at that level.

CHAIR—How can that be improved in undergraduate, let alone postgraduate, teaching?

Dr Van Loon—I believe that we have a fairly value-neutral curriculum in that if the person is not the centre of the curriculum then we have a real problem. I think many curriculums are centred on various different disciplines rather than on the person, and the movement back to a person centred curriculum would be, as I see it, the most fundamental step we could take to change that. You can cultivate attitudes—you cannot teach an attitude but you can cultivate it—and I think there are some shining examples of how that works—the University of Notre Dame is one that you should follow up if you wish to. That is a place where the values permeate through the entire curriculum and are not just about skills and knowledge acquisition. There is actually a whole organised attempt to cultivate an attitude as well.

CHAIR—Can you remind me which institution you teach at?

Dr Van Loon—I don't teach; I am actually researching at Flinders University. I am not teaching at the moment.

CHAIR—And you work in which institution?

Dr Van Loon—Flinders Medical Centre.

CHAIR—Thank you. Just to conclude, Mrs Hepper, I want to follow this up. I am a bit taken aback: in other places we would have heard that the operating theatre was the second sexiest place after the ICU. What is happening, as far as you know, about operating theatres? I would like to follow Senator Knowles's questions here.

Mrs Hepper—It may differ from state to state and school to school.

CHAIR—Are the doctors less handsome? You do know heavy irony when you hear it, I hope. I had better put that on the record in case I am misunderstood.

Mrs Hepper—Maybe they have younger staff, I don't know.

CHAIR—Would you argue therefore that it would be very important for every undergraduate nurse to be required to have time in theatre?

Mrs Hepper—As a perioperative nurse, yes, I would. I may be biased in my opinion as I am a perioperative nurse, but it provides a viewpoint that you cannot get on the ward. There are a lot of skills, and I am talking about skills here that we cultivate in the operating room which impact on the activity which occurs elsewhere with the care of those patients.

CHAIR—Such as?

Mrs Hepper—Such as things like a full knowledge of aseptic technique—sterility and infection control. It is very centralised with the care of patients in the operating room, whereas it is on a broader scale with the care on the wards, as we see it. It is very organised, and it can be seen as a very factory-like type of perspective to some degree. But you do assessment and plan your care within a shorter space of time, so you have to be very focused on the care that you provide.

CHAIR—'Perioperative' means that you meet them going in, when they are conscious, and care for them until they wake up again?

Mrs Hepper—'Perioperative' covers the areas of anaesthetics, theatre and recovery room. It may or may not be the same team that covers all of those aspects of that care, depending on the size of hospital that you work in. It covers the day surgery type of care, which is seen a lot more today. So we meet and greet them, put them to sleep and give the care that is required as part of their procedure, and then they go into the recovery room.

Senator KNOWLES—How many instances are there of specialty within the specialty?

Mrs Hepper—Quite a lot. Within my institution I have 12 clinical nurses for 12 different specialties, so there is a lot more specialisation within perioperative nursing than there ever used to be.

CHAIR—Senator Knowles, do you want examples?

Senator KNOWLES—No, I thought that would be the case, but I just did not know how many.

Mrs Hepper—It is highly specialised. The equipment that we use is so technically focused, and there are requirements. You used to be able to do any type of surgery, but you cannot now.

CHAIR—So that might be a case for why it has to be postgraduate?

Mrs Hepper—I think that the exposure for undergraduates is necessary. Seeing somebody having their back operated on influences the care that you provide them with afterwards. It gives you a different perspective on how they are positioned and on the sorts of things that we do which may influence them. Exposure in theatre to a laparoscopic procedure these days explains why someone would wake up with shoulder pain. If you do not have that exposure, you cannot understand why they wake up with aches and pains.

Senator KNOWLES—That is why I think it is important that the patient actually gets the information too.

Mrs Hepper—I agree with you.

Senator KNOWLES—For example, in a knee operation, it just looks like two little slits. When you see the video of what actually happens it is vastly different. But I do not think that

patients understand that either, so why would the nurses be any the wiser if they have not experienced it?

Mrs Hepper—That is true.

CHAIR—You have given us a lot of food for thought. Thank you very much.

[2.50 p.m.]

BROWN, Mrs Judith, CEO/Registrar, Nurses Board of South Australia

CUSACK, Mrs Lynette, Presiding Member, Nurses Board of South Australia

MARTIN, Ms Kae, Director, Strategy and Operations, Statewide, Department of Human Services

PRATT, Ms Debra, Principal Nursing Adviser, Department of Human Services

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 have to remind you that evidence to the committee is protected by parliamentary privilege. The giving of any false or misleading evidence could constitute a contempt of the Senate—I think that means intentional misleading. I think the departmental people would know, but I will remind you, that you are not required to answer questions on the advice you may have given on the formulation of policy or to express a personal opinion on matters of policy.

The committee has before it your submissions Nos 940 and 86. Do you wish to make any alterations to those submissions? If not, I will invite you to make a brief opening statement and then field questions.

Ms Martin—Thank you for the opportunity for the Department of Human Services to present today. Whilst we believe the submission presented to you represents the current identified issues in nursing within South Australia—and indeed nationally and internationally—the government and the department have made a significant commitment to strategies to support both recruitment and retention and the professionalism of nursing in South Australia. As you would be aware, South Australia's population is predominantly urbanised, with approximately 1.2 million within the metropolitan area and 400,000 in our rural and remote areas. Within the metropolitan area there are eight public hospitals and 10 major private hospitals. In the rural area there are some 60 hospitals, ranging from very small, remote units to regional centres of 80 to 100 beds. Certainly, the geographical location and the diverse nature of our population and the historical placement of health services within South Australia present unique challenges to the department in relation to the provision of sustainable, quality health services. Within the public sector we have responsibility for about 8,000 full-time equivalent nursing positions, which represent on a head count 12,000 nurses.

As I am sure you are aware, a new government was elected within South Australia recently. The message is quite clear within the department that the health and wellbeing of the South Australian population are of prime importance. The government, through the Minister for Health, have announced that the health agenda will be underpinned by five pillars: improving the quality and safety of services; greater opportunities for inclusion and community participation; strengthening and reorientating services towards prevention and primary health

care; developing service integration and cooperation; and adopting a whole of government approach to advance and improve the health status of our population.

A comprehensive generational review—and I will put ‘health’ in brackets there—will be undertaken, of which an announcement in relation to the timing and structure is anticipated for April. The review will provide the platform for the health reform in South Australia and aims to build relationships and create a climate of culture to deliver services.

A range of initiatives have been implemented within this state to support the recruitment and retention of nurses within our communities. These have included recently: the department and university partnership model, whereby a regular forum has now been established at executive level between the department and the universities with the prime role being to look at nursing enrolments, education and clinical placements; a review of our labour force model which has been utilised within the department for some 10 years, as a result of the projections within our submission; and provision of funding for 200 additional nurses in the last 12 months.

An additional million dollars was also allocated by the government for recruitment and retention strategies for 2001-02. Some of these strategies have included: a structured free fee paying refresher re-entry program, and at the end of 12 months we anticipate 150 nurses, both registered and enrolled nurses, would have completed this program; the funding of 40 additional undergraduate placements at two universities—the state has given additional funding to complement the Commonwealth funding; and the provision of 66 additional enrolled nurse cadetships in rural South Australia. This program is aimed at employing local people in the town. The student works approximately two days in the local hospital and the other three days undertaking their study.

We also provide funding for postgraduate scholarships. This year we are providing up to $310,000 for postgraduate scholarships within the metropolitan area, rural and remote, and to support Aboriginal and Torres Strait Islanders to undertake nursing programs. We undertook a significant marketing campaign. The outcome of that marketing campaign was information from the universities recently that it was the highest first preference intake into nursing programs they had experienced, and therefore the tertiary entrance scores were some of the highest they had received.

In addition, the department also funds nearly $13 million for the nurse teaching grant in the public hospitals. This funding provides for a range of initiatives which include the funding for the graduate nurse program, and this year 401 students will be going through their program. It also provides postgraduate programs for registered nurses and enrolled nurses, and we have a range of incentives and approved courses supporting those programs. It also provides funding for staff development at the local level.

In addition, we believe in getting to our youth in order to promote nursing as a career. The department has developed the schools speaking program and a job shadowing program, which has proven to be extremely popular with the schools. Importantly, nurses within hospitals really enjoy going out and showcasing nursing.

Senator KNOWLES—Did you say ‘job shadowing’? Could you please explain that?

Ms Martin—It is a bit like work experience or what used to be called work experience. Now it is about school students working side by side with a nurse and experiencing some of our programs.

Senator KNOWLES—In what setting?

Ms Martin—In a hospital setting or in a community setting. It is on a negotiated level with the health units. It has been quite common in the rural areas because they are more in tune with their youth. But it is a recent development in the metropolitan area. Deb is the developer of the program.

Ms Pratt—One of the things we actually had when we talked about work experience from a nursing perspective was a value set by nurses which said that you cannot allow students into the practice setting—because of confidentiality you cannot do the role of the nurse. So we reframed the thinking around that and use a concept of shadowing or buddying. Just by renaming it, it has a very different value and there has been a different reaction to it.

CHAIR—We will probably have to come back to this. It seems to me that the committee would be pleased to know what you have done with industrial concerns and with confidentiality and so on. Maybe I can give you notice that we will come back to that. Have you finished with that?

Ms Martin—Finally, the Premier in particular supports nursing scholarships for overseas research for four nurses per year. Importantly, the department sponsors the nursing excellence awards which coincide with International Nurses Day. This is the second year that it will be in operation and we have had over 200 nominations for 12 categories, which is a very pleasing effect.

I would just like to say in closing that the department has a strong commitment to ensure this state has an appropriate professional work force to provide services to our communities. We have concerns in relation to the future of the provision of a skilled work force to meet our changing demands. To quote a recent discussion from a focus group we held with young people: ‘It is something that my mother would do; it is not something that I would do.’ We have to accept as a society that opportunities for young people are wide and vast and exciting, and lifestyle choices are important. However, we also have to accept that the provision of health services is a 24-hour, seven-days-a-week, 365-day service and, in order to provide this, we have to look at opportunities that meet the expectations of a new work force.

CHAIR—You said that the Premier supports four overseas scholarships. Is that the outgoing premier or the incoming premier?

Ms Martin—Both governments have supported the process.

CHAIR—That is a very good answer, Ms Martin. The incoming government will continue the same policy?

Ms Martin—Yes.

CHAIR—The scholarships are for South Australian nurses to go overseas?

Ms Martin—Yes. That is to the value of $15,000 per scholarship. The health unit also supports their study leave with pay.

CHAIR—So that would not be a full year away?

Ms Martin—No. It usually ranges from four to eight weeks.

CHAIR—Thank you. Perhaps we should hear from our witnesses from the nurses board.

Mrs Brown—The Nurses Board of South Australia welcomes the opportunity to respond to the Senate Community Affairs References Committee inquiry into nursing. The nurses board is an independent statutory authority, whose primary role is the regulation of the profession of nursing in South Australia under the auspices of the Nurses Act 1999. The nurses board has a mandate to ensure that the community is adequately provided with nursing care of the highest standard and that high standards of nurse competence and conduct are maintained, in the interests of the public.

As an independent statutory body, the board has clearly defined legislative authority and responsibilities. The response of the board, therefore, in addressing the inquiry attempts to encapsulate the issues within the function and role of the board. In our submission, we have identified the functions of the board under section 16. The Senate inquiry terms of reference involve a number of domains that are clearly outside the statutory role and function of the board. While the board's primary role is the regulation of nursing—as I said, in the public interest—the Senate inquiry requires investigation into topics that involve information or regulation that is incorporated within the provisions of other legislation. An example would be the industrial regulations law. The board is then of the view that the problems associated with current nursing and midwifery shortages are more directly related to employer regulation than to statutory regulation.

In its submission, the board has provided information on key issues associated with its statutory role. Those issues have mainly centred on the approval of education programs by the board, the enrolled nurse supervision, the authorisation for unsupervised practice—which is a new direction for the board, under the new act—and the authorisation of nurse practitioners. In September 2001, the board approved a professional standards statement for nurse practitioners to practice, following extensive consultation with key stakeholders and the profession, and is also working with the Department of Human Services to include nurse practitioner prescribing within the Controlled Substances Act. The board will be prepared to receive applications from registered nurses who are seeking authorisation as a nurse practitioner by the end of April this year.

The introduction of authorisations for unsupervised practice for enrolled nurses, as well as the development of the nurse practitioner, has allowed, in the public interest, the provision of nursing care where there are evident deficits. The board is of the opinion that government should support further development of the nurse practitioner role across Australia, as a viable component of health care services. The current approval framework for courses leading to

registration and enrolment provide a fair and equitable framework and allow other registered training organisations the opportunity to develop curricula to meet the labour force deficits.

While the board does not have a direct role in the determination of factors that influence the nursing shortage in Australia, it has tried to utilise its regulatory authority to provide alternative, long-term solutions to the current crisis.

Senator LEES—I would like to ask some questions of the South Australian government representatives. Just looking at your submission, I thank you for the amount of detail in this submission in terms of the actual data. We have been asking quite a few of our witnesses for a lot of this detail. I note that on page 17 you say that the current graduating numbers—we are now talking about registered nurses—fall into the worst-case scenarios in terms of actually trying to keep up with demand here. As you have factored in how many nurses we are going to need, obviously you have looked at the numbers graduating. But, as well as the ageing of the nursing work force which you cover on page 13, have you looked at the ageing of the population and what seems to be, from hospital acute admissions, an increasing number of people actually going to be using our hospitals? Can you put all those factors into getting those numbers?

Ms Pratt—The labour force model that we used to do this projection was not as broad as that. The model itself actually looked at the length of time that a nurse actually remained in the nursing work force. Through the 10 years of work that the department has had in using that model it has been able to establish that on average registered nurses stay in the profession for about 15 years in South Australia and for enrolled nurses about 13 years. So the modelling was based on that.

Senator LEES—And you are presuming the number of hospital admissions basically stays fairly static.

Ms Pratt—Reasonably static, though at the moment the department is going through a restructuring process looking at how it actually wishes to look at work force modelling as a whole department. So we are actually about to undertake a review of our work force model, because there are a variety of models that can be used taking into account a lot of variations.

Senator LEES—Looking at how many you are going to need in community care and how many you are going to need in aged care, in the future are you going to factor those into the model?

Ms Pratt—Certainly we want to have a look at an alternative model that has a greater degree of variance to it.

Ms Martin—At the time when the model was being developed, with the change of technology in the introduction of the same day surgery, for example, there was a factor looked at that you needed fewer in-patient 24-hour nurses because of that. Therefore our projections were starting to go on a downward trend, but in effect what has actually happened, because of the ageing of the community and the high complexity, is that we are actually requiring more nurses. That is why our trend is going up.

Senator LEES—I was actually in the health portfolio in 1992-93 when same day surgery took off and it was supposed to cut across the trend: as it went up, those people in beds would go down. This leads me to the next question. Have you looked in South Australian hospitals at how many people are under this line of overnight stay patients who really should be elsewhere, whether it is nursing home, whether it is looked after in the community, whether it is perhaps a mental health issue that has a more appropriate place or whether it is drug and alcohol related. Have you got any statistics on that?

Ms Martin—We have not actually got any firm statistics, but there is certainly a growing body of evidence suggesting that if we had increased community support services, especially in the mental health area, the length of stay could be reduced and/or it would prevent an acute episode occurring which results in an acute inpatient admission. For us as a department to actually get that, we need what we call hump funding, an injection of one-off funding so that we can actually develop the infrastructure to support the community based services so that we can actually reduce the reliance on acute episodes within hospital.

Senator LEES—And you are doing nursing work force planning to look at that scenario, as well as a continuing trend to keep elderly folk stuck in hospitals.

Ms Martin—It is definitely not a continuing trend to keep elderly people and is not one of our philosophies—

Senator LEES—I realise that, and we are not going to get into the buck passing to the Commonwealth for nursing home beds, but they are some of the other scenarios that you are looking at.

Ms Martin—Absolutely.

Senator LEES—Which I guess would be a better use of dollars.

Ms Martin—Certainly, the Commonwealth and state governments have a joint project in the transition care project, which is about additional community aged care packages. It is a collaborative project between both governments to support more people in the home, which has been extremely successful.

Senator LEES—As we have heard in evidence before this committee, they are also short of nurses, which is holding that back in terms of realising the potential out there for those who want to stay in their communities. Can I just bring you to some more evidence we have had. This is our last day of hearings so it is good to be able to have a department here, in this case from South Australia, to look at what other departments have said and are doing. Victoria addressed the issue of the number of patients per nurse and they made some changes in what nurses were expected to do. We have asked for some actual hard evidence on the results, but the results seem to have been that more nurses were attracted back into nursing because they felt the workload was going to be more realistic and they were actually going to feel they had some job satisfaction. Have you looked at that or is the new government looking at that in South Australia—to actually put some money into the hospitals to get more nurses on the wards?

Ms Martin—In our recent enterprise agreement the government funded 200 additional nursing positions. We need to achieve that target by April 2002. To date we have 170 full-time equivalent positions of those 200 funded positions. That is not activity related so that was just 200 nurses to go into the work force.

Senator LEES—To boost where? Have you got a breakdown per hospital of roughly where they are all heading?

Ms Martin—Yes. They were targeted towards the acute care areas in mental health and emergency departments and the critical care areas of renal and cardiac services. If you would like the particular hospital details—

Senator LEES—That would be really helpful just to give us a bit of an overview so we can compare state to state—what is working, what is not working—so that as we make our recommendations we have something to compare it all with. Looking at the scholarship schemes—and you also touched on some of these in your introduction—can you give us some idea of the successes? I take it some of these are fairly new. You also mentioned the Ceduna Pilot Project. I was able to meet a couple of the kids involved in that when I was up there. Have you got any material on how successful the schemes have been? Have the people who have gone through those processes actually committed to nursing and are they sticking with it?

Ms Pratt—The Ceduna Pilot Project was to be evaluated at the conclusion of 12 months and that is coming up now. What we actually did within the department, because of the value of being able to link secondary students with school and TAFE and look at possible employment pathways for them, was to roll that out to all regional and rural and remote areas so each hospital in a rural and remote area could pick up on that model if it was going to work for all of those three people together. We are really in the early phases so there is no longitudinal outcome that we have seen.

Senator LEES—Is this with VET in schools?

Ms Pratt—It is with VET in schools so it is actually looking at the students entering into TAFE to do certificate II. It is hoped that at the conclusion they will graduate from certificate II, but it leaves them at school and it also exposes them to a health care environment, so if they wish to then continue on into either an enrolled nurse program or a registered nurse program they have been given a foundation from which to step for that.

Senator WEST—Can I just follow that one up. We had the problem raised this morning of those who do their certificate II under VET; that is, as a traineeship. If they then leave school and continue on and want to undertake some other traineeship, they are not eligible for it.

Ms Pratt—Sorry, in what way?

CHAIR—That is a very good question, Ms Pratt.

Senator WEST—We were told that they became ineligible for a second traineeship to go on to do, say, certificate III or certificate IV.

CHAIR—So in fact the authorities have now cancelled the eligibility of those doing certificate II to do certificate III. It certainly puzzled me at the time too.

Ms Pratt—I have certainly not heard of that. The other thing that we have done is to create a cadetship model, which is based on a traineeship model, where we are supporting 66 students, again in rural and remote areas.

Senator WEST—To do what?

Ms Pratt—They undertake certificate IV to become an enrolled nurse. They work for two days at the hospital, because part of the issue that we have heard about is that, to undertake the training, you have to work to provide funding for your family and all of those things. Taking that on board, we have looked at how we can provide employment and support people while they undertake their training, and keep that loop with their education preparation and the health service. There has certainly been a lot of interest shown in the country areas for that. I think 37 health units have picked up that model and students have started in TAFE this year.

One of the significant issues for the rural and remote areas is that it is not necessarily ENs that we need there but registered nurses. A lot of people come to the metropolitan area because that is where the university programs are provided. Many then do not go back to their local area, and certainly some of the councils are saying, ‘How can we bring our young people back to our country areas and back to our hospitals to work?’ So there is a lot of concern within communities about how we can keep young people not only in the community but in the health system as well.

Ms Martin—Following on from Senator Lees about the scholarship program, I think for about eight years the department has been supporting 20 health site scholarships, which are for doctor, nurse or allied health undergraduate scholarships for rural people. That is an application pro forma and they have to have lived in a rural area for three years. They get bonded back to a rural community for however many years the scholarship was for. That has been quite successful. Nursing tends to be one of the leaders in the successful applications in that area.

CHAIR—I interrupted Senator West and I want to follow that up, if I could. Is there any information about why certificate IIs could not go to certificate IIIs? If you could find that and provide it to the committee, that would be very useful.

Senator WEST—I would like to go back to when you said that the councils were worried that nurses would come here to do their RN and then would not go back. I have a bit of a problem with that. There has been justification for money being spent in other areas to enable rural people with some qualifications to come to the city to get more highly qualified, because they in fact do show a predominance to go back, maybe not to their rural community but to rural areas. Who is telling us the truth here? Are the councils just saying that they do not want to lose their kids at any stage, that they have not caught up with the 21st century and do not recognise that nursing and health care has changed a hell of a lot and, therefore, that kids do need to have a tertiary education? Is there something different in South Australia compared with the other five states and two territories?

Ms Pratt—I think there is a large degree of variance about where people's beliefs and values sit. Certainly in the conversations that I had, it was that, 'Well, our nurses don't need to be prepared the same in the country because they're not doing all the newfangled things that you do down in the city.'

Senator WEST—Isn't that giving them a second-class education?

Ms Pratt—Absolutely.

Senator WEST—I have a nursing background. Isn't that what we have fought about for the last 40 years?

Ms Pratt—Absolutely. Certainly I tried to work through this with the people concerned. Part of the challenge for rural and remote areas is that they have very stable staff—people work there for a very long time. One of the other issues is: how do you get that new blood coming in? Unless there are positions for people to move into, it is a real dichotomy between having that level of experience, bringing people in, how various people perceive what their needs are within the community and what educational preparation people might need. There is a lot of diversity out there.

Senator WEST—How do we get those, who are not moving, out? Presumably, they are not moving down to Adelaide either to undertake postgraduate courses and services. How do we—and this probably brings in the NRB—make sure that they do maintain a skill level that is appropriate for the 21st century? The tractors roll over just as easily and you get the same sort of head injuries from motor vehicle accidents up there as you do down here on Rundle Street or wherever, and probably the vehicles travel faster up there with fewer speed restrictions.

Ms Pratt—Absolutely.

Ms Martin—I think it is important to separate two things here. I think one issue is what local councillors think their nurses are versus what nurses actually are. I am a rural nurse and come from a rural background. We are used to 'womb to tomb'. I use the term 'womb to tomb' because you never know what is going to come through the front door—you can have a baby one day, have someone die in palliative care and have a road accident in the middle. Rural nurses are very skilled nurses. They have extremely good assessment skills and have extremely good relationships with their general practitioners. I think there is a strong commitment to their continuing education. We have run a range of programs—a recent one, which Deb facilitated, was upskilling for midwifery. Our birthing numbers are down but we still have to be prepared for those circumstances. That has been an excellent program that has been supported by our rural midwives.

We also have our trauma nurse coordinators who regularly go out to the regions to provide whole-day sessions on trauma management and emergency management. Like you were saying, an operating room is not sexy, but these courses get flooded. The difficulty for us is that perhaps the aged care programs, which the majority of hospitals are looking at, are not sexy and nurses do not come to those programs. But there is a very strong, conscious effort for nurses to maintain their skills in the rural areas, but it is the attitude between the councillor on the—

Senator WEST—What do governments, both state and federal, need to do to educate rural communities as to what an appropriate health care service is for them and what their needs are? It means more than acute hospital beds and doctors.

Ms Martin—I think there have been some really excellent programs that the Commonwealth and state governments have done in relation to that. Multipurpose services have been developed in a range of rural towns. Primary health care initiative funding has been supported into rural areas. There has been a lot of collaboration by regionalisation and looking at a region and saying, ‘What are the key services that our population needs?’ and demonstrating that through the demographics, the health status and our social health atlas, which South Australia has. It is informing the community and having the community involved in the service planning of health services that has actually started to change. Again, it is not something that is going to happen overnight, but there is the consistent message saying, ‘South Australia has the oldest population. We have a declining population; we have a declining birth rate. We actually cannot afford the services that we have now. How best can we use the services to maximise our resources and make sure our community can move forward?’ I think it is that constant education, publicity and involvement of consumers and key stakeholders in our planning process.

CHAIR—Ms Martin, would you be able to provide to the committee a copy of the latest social health atlas?

Ms Martin—Certainly.

CHAIR—You have had it for a long time.

Ms Martin—Yes. We have had a second revision. It is excellent documentation.

CHAIR—How old would it be?

Ms Martin—The latest version, I think, is 1998.

CHAIR—I keep insisting that South Australia is first out with anything innovative.

Senator WEST—There are health atlases in parts of New South Wales.

CHAIR—I am very pleased that they have followed South Australia’s example. I know that New South Wales produced some very good atlases about, for example, all the hospitals where babies were born, interventions and so on. I understand that was picking up an initiative that had happened in South Australia. We are not at war here, but I wonder if you could provide a copy of the latest one to the committee. If there is a page inside that saying how long it has been happening, that would be helpful, too.

Mrs Brown—Could I just add the board’s view on continuing competence. The board views that very seriously. It also gives out the indication to the profession that they should view it seriously as well in terms of registration. We do have a stat dec that we ask everyone to sign to renew their registration, and they have to declare their competence in the area in which they practise. In other states I am aware that they do an audit process where they take a slice of their

nursing population and audit the competence, and they then ask people to provide portfolio information on how they would achieve those competencies.

In South Australia we would like to take another initiative—a different approach to that. We believe that employers also have a responsibility to ensure the continuing competence of the people that work for them. So we are looking at an approach where we will be working with some major organisations, both metropolitan and in the country, to see how we can actually establish a process whereby we can ensure the competence of people working within those organisations. We have got a pilot program that we are establishing over the next two years, and we will be evaluating that at the end of that time.

Senator WEST—That brings me to a question on information that we got yesterday in Queensland relating to the fact that, if you have got an employer or an organisation that is not doing the right thing, there is nothing that the NRB—or whatever you call yourselves—can do to actually make that employer do the right thing, have the right practices, and things like that. Is that the case in this state? If there is a general complaint about a facility, are you able to go in and check the nursing levels and standards there, or do you have to react only to a complaint against an RN or an EN?

Mrs Brown—Under the act we regulate nursing; we do not regulate the industry. So in answer to your question, the complaint would come against the nurse. If, during the hearing, there was evidence given to the panel that there were system problems within that institution, the board would certainly put that into their decision. They would ask me, as the registrar, to contact that organisation by correspondence or informally to give them that information so they could do something about policies or procedures that were not, in the board's opinion, adequate. But that is the only power that the board have under the act.

Senator WEST—Probably aged care is the example that springs to mind, but across Australia and internationally there have been some failures of systems where RNs as well as other health professionals have been involved. But with the failure of the system, would you have no power to go and look at what the nurse's behaviour has been like so that you could actually be pre-emptive if there are complaints about a system?

Mrs Cusack—Certainly under the legislation we do not have that power. Through the process of investigation, if we receive a complaint then the nurses board staff can go into that environment as part of their investigation. But it is not until it actually gets to a hearing, and where board members are very concerned about the systems, that we then take the initiative to write to that service outlining our concerns—while being fully aware that we do not really have the authority. If they choose to ignore our letter then there is nothing that we can do. The board are in the third year of their term. The current board have been very concerned that a number of nurses come before us where it is not really an issue of their competence; it is really system failures that have let them down. That is why we have been very active—

Senator KNOWLES—So you cannot refer that anywhere else?

Mrs Cusack—No.

CHAIR—Off the record?

Mrs Cusack—Not formally, no.

CHAIR—One says, ‘No,’ and the other says, ‘Yes.’

Mrs Cusack—I think they were agreeing with what I am saying. Informally, we can. We certainly meet with directors of nursing—we meet directly with the ANF, the Royal College of Nursing, midwives and universities, and we discuss matters that are coming before us and our concerns. But it is an informal meeting.

Senator WEST—So no-one has got a sledgehammer with which to crack that nut that needs to be cracked?

Mrs Cusack—No.

Senator KNOWLES—No-one has even got a nutcracker, never mind a sledgehammer!

CHAIR—Can we just illustrate this with an example. We have been very concerned about the competencies—what are they called?—that nurses are supposed to have to do what they are accredited to do.

Ms Martin—The ANCI competencies.

CHAIR—Thank you. To do this, they need clinical experience as part of the process, and they are therefore placed in places where they can get clinical experience. Some of those clinical experience places are awful. We do not have a list of names, but witnesses from another state were saying, ‘The word is out: you do not send anyone there for clinical experience.’ As I understand it, you can accredit courses.

Mrs Brown—Yes, that is true.

CHAIR—In investigating courses, would you not be able to pursue very inappropriate clinical placements?

Mrs Brown—Yes, part of the approval process for courses is to look at the clinical placements. We look at the collaboration that takes place between the university and the health care establishment to see if the qualifications of the people who are actually providing—

CHAIR—If you find a place that is awful—you know it is awful and you certainly know you would not recommend any student go there—what can you do?

Mrs Brown—I guess, once again, we would use that informal process. That is probably all that is open to us in providing that information to the university.

Senator LEES—So you cannot go back to the state government, say, if it is a small hospital where the state government may have the authority?

Mrs Brown—No.

Senator LEES—As Senator West was getting at with earlier witnesses, problems in the aged care area often start to surface with a huge amount of paperwork or someone saying, 'Nurses in that nursing home have terrible practices,' when in fact it is the nursing home. Once you are aware that a particular nursing home is an issue for nurses and that the issue of quality needs to be sorted through, one way of cutting through the enormous amount of paperwork that the nurses are stuck with might be for people such as you to be able to immediately refer it off at a federal level. Is that something that would work if your act were changed?

Mrs Brown—Absolutely. As I said, we are powerless at the moment to do anything except on an informal basis. If we had processes where we could actually refer to appropriate agencies, it would certainly enable the board to have more teeth, as it were.

CHAIR—You say that you are powerless to act. Is your act silent in areas that would enable you to write formally to your colleagues at the other end of the table, for example, and say, 'We have been given to understand there is grave concern about X; we believe you should follow this up?'

Mrs Brown—We investigate nurses. The complaint is made against the nurse; it is not usually made against the institution. We are investigating the conduct of the nurse. If it has been a systems failure and we have found that there is a trend within that organisation, we could certainly supply that information. Usually we find that, if there is a complaint from a public institution around a nurse from a particular organisation, the department will have conducted an investigation before that complaint may even have come to the board. The department, for instance, may already have that information about that particular agency.

CHAIR—You are telling us, though, that you cannot act?

Mrs Brown—In a formal way, under the powers within our act. The hearings are held in private, and a lot of the information is confidential.

Senator KNOWLES—How effective is your informal communication to the university? While you say that you can informally go to the university and say, 'Hey, steer them away from there,' do they listen to you?

Mrs Brown—It is extremely hypothetical at the moment. I have been in the position for the past year, and I have not had an instance of this occurring where I have had to go back to a university and tell them that a clinical placement is less than adequate.

Senator KNOWLES—It is hypothetical, and I do not want to add to the dreadful media hype that all aged care institutions are shockers, because they are not. I think we would all agree that 99.9 per cent of them are fantastic. But you have that part of a percentage giving the rest a bad name, and the good ones pay the penalty for the crook ones. What we are trying to get our heads around now is how to ensure that the good ones do not suffer a penalty because of the very few rotten ones and that the undergraduates do not suffer a penalty by being sent there for clinical experience when it is not necessarily a desirable place.

Mrs Cusack—I think it is very difficult for the board in that our main link with students is our ability to accredit the university courses. Then we have to step back and make the assump-

tion that the universities will do the right thing in assuring the quality of delivery of that curriculum. The nurses then come back to us to seek registration. So we have very little to do with the student nurses. It is only once they come to us to be registered or enrolled that they link back to the regulation authority.

Senator KNOWLES—But what happens then if you look back and you say, 'Uh-oh, this poor character has been exposed to that place, which we didn't think was all that flash'?

Mrs Cusack—They go to a range of different places throughout their training, and in my 2½ years I have never had the experience where I would be able to identify a single clinical placement. I can identify workplaces as registered nurses and enrolled nurses come to the board, but I could not identify factually any clinical placements that have not met the standards. I would make the assumption that the universities are undertaking that process, and the employers have that responsibility too.

Ms Martin—There are two processes. I know we are talking about clinical placements, but there are also issues around critical incident reporting. If there are issues of nurse failure, system failure or doctor failure, there is a process within the public hospital system for them to be reported through to the chief executive and/or the minister's office, and on a range of occasions there have been formal investigations at health unit level in relation to critical incidences. Speaking from the experience of being a director of nursing and from a clinical placement perspective, there is reasonable feedback between a university and students following debriefing of clinical placements. The students are very up-front and will let their university lecturers know if it was not a good experience. Even during a placement they will not hesitate to contact their supervisor. There have been instances where placements have changed. Sometimes that could be because of a personality clash or sometimes there are other personal factors or whatever. It is my understanding that the university placement coordinators are very approachable by their students in relation to a bad experience or whatever, and they know which places maybe not to go to.

CHAIR—We had a similar experience given to us, that the academics in Queensland knew full well which places you did not, if possible, send students to. It was not exactly a black list; it was just that students were not sent. Interestingly, three different institutions were all avoiding the same place once they had got wind of how insufficient it was. That worried us because it is one thing to make sure the students get good clinical placements. There is another concern about a place that is so insufficient that you would not send students there. What is that doing in terms of the standard of patient care? That is another concern.

Ms Martin—From our department's point of view, we would be remiss in our duty of care if we were letting that happen.

CHAIR—Do universities ring you up and say, 'Off the record, we have just had students back and they said whoopy-do about that place?'

Ms Martin—The issues that we have received from the universities are that the hospital situation is so busy that sometimes the staff do not have the time to devote to one-to-one clinical teaching, and they appreciate the demand that the system is being put under. Therefore universities have come up with a range of models. For example, Flinders University use the dedicated

educational unit, which has been extremely successful from a student's and a clinical teacher's perspective. They are looking at alternative models for clinical placements which meet the expectations of both providers and students.

Senator LEES—I just have one more question. On page 16 of your submission you talk about the number of graduates—around 400—and that for 2000, the last year for which you have figures, the actual number was 389. Yet on the next page you say that between 650 and 1,350 are going to be needed. What is your department's plan to sort this out?

Ms Martin—Our department's plan is to carry out a formal review of the labour force model. There are some concerns about whether the labour force model is projecting appropriately. There are different views in the department about that and those views are nursing versus non-nursing views. As a result of that, we are going to have a full review of the labour force model.

Senator LEES—But whether it is 650 or, as others have suggested, around 780 or whatever, we are 500 short now and we are going backwards, partly because we have a huge bulge of nurses in their fifties who are going to look at retirement 10 years down the track. We cannot get the clinical places now and the universities that appeared before us this morning are having an interesting discussion about how they are juggling that, particularly with Adelaide University considering starting an undergraduate course. What is the state government able to do, even if your top figure of 1,350 is too high and we bring it back to 700 or 800 a year? We are not even half way there. What is your department's view on how to fix that?

Ms Martin—We believe that the intake into the nursing programs is about appropriate; it is a matter of the number of products that we get out of that project. There is a debate about the attrition level within the program.

Senator LEES—What is that?

Ms Martin—The universities quote between three and 10 per cent, but we think it is up to 30 per cent. The issue is that it is a mobile work force. They choose to go to other areas rather than return to the hospital situation and/or they choose to go into another degree program. At the end of the day, the number of nurses coming out does not necessarily match.

Senator LEES—So, to get the right number, are you considering recommending an increased number going in?

Ms Martin—No. With the universities, we are suggesting that we would like to have X number come out. We want to turn it around and say, 'Okay. You don't need more in. We want an assurance that we have 600 nurses come out to meet our targets.' That puts the responsibility back on to the universities to ask, 'What's wrong with our program? Why don't students want to do nursing?'

Senator LEES—They are saying that there is a drop out after the universities have finished with them. They get into the hospital for the first year and then perhaps 40 per cent of them vanish. Is there a role for the state government in respect of that first year out to have extra clinical placements through your hospital funding?

Ms Martin—We have a structured 12-month postgraduate program year for which 50 per cent of the salary is funded. The programs are managed by the hospitals with education and mentoring attached.

Senator LEES—Is there an upper limit?

Ms Martin—As in the number of students?

Senator LEES—Yes. How many are you funding this year?

Ms Martin—We are funding 401 because that is all the students who came out. Actually, about 480 came out, but the private sector took some on.

Senator LEES—Could you take that up to 600 if necessary? Do you have the funding to do that?

Ms Martin—We could adjust our funding base to do that.

CHAIR—If more nurses are coming out, why did the TER score go up?

Ms Martin—The TER score went up for the first time this year.

CHAIR—Why did it go up?

Ms Pratt—We believe that the quality of the students applying held a higher TER score. Because of the numbers applying, the universities were able to cream the crop, if you like, and take the higher TER score cohorts.

CHAIR—I am pleased to have that sorted for me.

Ms Pratt—We believe that part of the marketing campaign that we ran over the past 12 months aimed at raising people's awareness of the nursing profession provided an opportunity for people who may not have chosen nursing as a career option to choose nursing.

CHAIR—You have a labour force committee in South Australia. There are proposals for a national nursing work force committee and something like a chief nurse in the Commonwealth. Would that be a problem for you? Would it be an irrelevance or a help?

Ms Martin—Do you mean personally or professionally, or from the department's point of view?

CHAIR—Preferably from the department and professionally.

Ms Martin—I will speak from the department level and Debra can speak from the professional level. From the department level, there have been concerns about whether or not we need chief nurses at a state level—and I have two ex-chief nurses each side of me! Off the record, I do not support that personally. The issue of the requirement to have senior professional

support at a department level has been raised. I am not quite sure what the new government and our new chief executive will take from that position, but that position has certainly been put at a national level when the role of the chief nurse at the Commonwealth was raised about six to nine months ago.

CHAIR—And the position, to make it clearer, is that there was not much support?

Ms Martin—Yes, not much support from the departments.

CHAIR—If you have a labour force planning committee at the state level, would a national nursing work force committee be a plus or a minus?

Ms Martin—I think it would be a plus, on the proviso that we could have collaboration with all the states and we were counting and using the same methodology. At the moment, we do not. It is all different, and everyone comes with their own methodology, and one is better than the other, and when you get at the state minister's level or the state health chief executive officer's level, it is a question of whose is better. There has to be national consistency.

CHAIR—We read on the front of the *Advertiser* two days ago that insurance for midwifery students is being withdrawn. Is that right?

Ms Martin—Yes, it was raised as an issue with the department about a month ago, and Judi might be able to elaborate, that the insurers of both of the universities had been put on notice in relation to insurance to cover both medical and nursing at Flinders University and nursing at the University of South Australia, in relation to midwifery programs. I contacted both the universities at that time and was informed that they were still negotiating with their insurers and that they were waiting for an outcome at the end of March as to the position of their insurer on this process. We confirmed that last Friday at the director of nursing meeting that we have with the universities, and that was still the position at that time. Then I read the paper, too.

CHAIR—Who are the insurers?

Ms Martin—The universities have their own insurers, and I am not familiar with the names of those insurers but, again, it is the same principle that bars their students and they are responsible for covering their indemnity insurance while they are students. If they were employees within the public health sector, they would come under our insurance programs.

CHAIR—I think somebody told me this morning that they understood that some of the students were covered by insurance through student unions. Do you know that to be the case?

Ms Martin—No.

CHAIR—To what extent do you concern yourself about these issues? Do you leave it to the universities or, if it were the case that someone suddenly rang up and said, 'We cannot teach anybody in this state anymore how to be midwives or how to be medical students because they are uninsurable', how would you manage?

Ms Martin—As a government department there would have to be some discussion with the universities and education because, again, it is about 'how long is a piece of string'. We have had this issue with independent midwives—private midwives—who have had their insurance withdrawn recently. They were seeking government support for their insurance arrangements as private practitioners. As a principle, the government does not support indemnity insurance for private practitioners. That is the role of private business, and we are insurers for the public system.

CHAIR—Could you tell us who the insurers for the public system are?

Ms Martin—In South Australia we are self-insurers.

CHAIR—That covers just about everything you need?

Ms Martin—In the public hospitals, yes.

CHAIR—Are all students working out of a public hospital covered by that insurance?

Ms Martin—No, because the students are not our employees; they are students of the university. We have not employed them.

Senator KNOWLES—I come back to the issue of country practice for nurses. From the state perspective, what have you done about accommodation, facilities and things like that to put them somehow on a par with the local policeman, the teacher and all those others who are doing a service in the bush?

Ms Martin—For example, if a nurse wants to relocate to the country, they can apply for a relocation allowance. We have administrative circulars which set down the rules for that. Certainly a lot of towns have looked at opportunities for housing, especially family housing, and they either negotiate housing trust stock or with councils, or something of that nature. Certainly a range of incentives has been provided in remote areas for nurses to go into those areas—like two weeks on, two weeks off and travel back home again. So ranges of different packages are usually negotiated at a regional level, depending on the areas that are looking for nurses.

Senator KNOWLES—I am from Western Australia. There is a slightly different problem there, because we have some really far-flung places with minimal facilities in many cases. Here in particular I am driving at accommodation. At various places around Australia you will find that nurses are expected to go and share accommodation where the local teacher or the local policeman is not; that nurses do not have an environment where they can take a family. That seems all pretty unsatisfactory, and I just wonder what the situation is with a level of basic accommodation that you will not go below for a nurse in a country town.

Ms Martin—We do not have actual standards. That is usually negotiated on an individual level. Certainly for director of nursing positions, there is usually a hospital house available and some quite good flat accommodation. But the old nurses' home type concept has gone; we just do not have the nurses' homes available. It depends on the town and the region as to what type of accommodation is available. There have been particular areas where you just cannot get ac-

commodation—it could be a seaside town where all accommodation is extremely valuable. But a lot of effort is put in at the local level if they can attract people.

Senator KNOWLES—Do you have many one-horse towns where it is not a case of having a team of nurses; it is really a case of having a doctor and maybe a couple of nurses?

Ms Martin—I think we have about eight to 15 one-horse towns where there are just nurses, no doctors, and they are serviced by the Royal Flying Doctor Service. Certainly at those sites the accommodation is attached to the health centre and, again, there are varying degrees of sophistication with those.

Senator KNOWLES—Would they be suitable for families though?

Ms Martin—They would be suitable for families.

Senator WEST—No caravans?

Ms Martin—No, no caravans. But it is usually not a preferred option for a family, because of the location of schools and stuff like that; you usually find that it is single accommodation.

Senator KNOWLES—I want to come to the board's role. We have heard a fair bit about the development of the role of the nurse practitioner. Some are for it; some are agin it. You are for it. Would you mind expanding on the reasons why you support that role?

Mrs Brown—The board is working with the department, and has done so over the last three years, and the board's role has been around authorisation. The board believes that it is a very important development in the nursing role. It is about nurses being educated to advanced practice and then being able to work in an extended role. I had the opportunity this morning to speak with a neonatal nurse practitioner from New Zealand who was telling me about her practice and the sorts of services that she can provide.

One of the things that she impressed on me was the continuing acceptance from medical colleagues, in that a lot of doctors working within neonatal units and, indeed, within obstetrics have reached the point of burnout. The neonatal nurse practitioners have been able to come into the services in New Zealand and provide services that usually were only provided by medical officers. They have become, I guess, assistants and partners with consultants. They have been able to undertake retrievals where they are the primary health professional. Because of all of those examples, the nurse practitioner movement within South Australia can only look to fill the gaps, the deficits, that we see in services. Some would say the gaps are particularly in rural and remote areas; I would say that those gaps and deficiencies are also in metropolitan services. This is a role that creates a tremendous opportunity for services to the South Australian community.

Senator KNOWLES—What does the government think of the proposition of nurse practitioners—probably in conjunction with telemedicine and all that is now more readily available than it used to be for those one-horse towns that really used to be away from the world but now have greater access to consultation and information?

Ms Martin—As Judy indicated, the department has been driving the nurse practitioner role. Again, it started off in relation to our rural and remote nurses who were actually practising at an advanced level but were not being recognised for that and, in some areas, were practising outside their recognised role. That was purely because there was no doctor or the doctor was in the plane somewhere else. So the department is extremely supportive of the nurse practitioner role and has contributed significant funding to the development of that role. It sees it as ranging from rural and remote areas to specialist units within our acute health services. It has come up through the recommendations of our clinical service reviews, for example, to have nurse practitioners in our emergency departments in areas where there is a lessening of GP after-hours services but where an experienced nurse practitioner in the role of provider of primary care could actually start to fast-track some of those clients through the system.

CHAIR—Aren’t there any in existence in South Australia?

Ms Martin—They are not recognised formally, but we certainly have a range of nurses who are practising in advanced level roles.

Senator KNOWLES—What about their indemnity if something goes wrong?

Ms Martin—If they are employed by the public sector, which we are advocating, they will be covered by our indemnity.

Senator KNOWLES—I am fully aware that people in the proverbial one-horse town never really have time off, and so it is not a case that they are there from nine to five and, if you get sick after that, too bad. But if they are theoretically off duty, if there is such a thing, does your indemnity cover them for that time as well?

Ms Martin—If they are recalled to duty—because in effect that is what happens—they are covered.

CHAIR—No; say that they stopped to pick up a drunk after a night at the movies, they lent some care, something went wrong and now they are being sued: will you cover them?

Ms Martin—Absolutely, because they are recalled to duty and it is a part of the philosophy of that service. Nurses go into those services knowing that it is a 24-hour service. Certainly with the recent enterprise agreement and with the introduction of the nurse practitioner role, remuneration goes to those positions as well, which again is an added recognition of that role.

Senator KNOWLES—How much more do they get?

Ms Pratt—It is based on an on-call allowance.

Ms Martin—The nurse practitioner level is.

Ms Pratt—The nurse practitioner level has been banded in South Australia at what we call registered nurse level 3, band B and C.

Senator KNOWLES—I am glad I asked that question!

Ms Pratt—Within the nursing structure within South Australia we have a director of nursing at level 5, assistant directors of nursing at level 4 and clinical nurse consultants, nurse managers and nurse educators at level 3.

Senator KNOWLES—How many extra shekels do they get?

Ms Martin—From an RN1 to that band, it would be—$10,000?

Ms Pratt—No, it is more than that.

Ms Martin—We can provide you with the salary ranges; it is significant.

Senator KNOWLES—If there is a significant incentive, that is good—to say nothing of the reward.

Ms Martin—Part of that recognition through the nurses board is that they can demonstrate advanced practice. There is also the postgraduate masters level programs that support that role, which the universities have been working on.

Senator KNOWLES—A number of groups have talked about the establishment of a national registration system. What do you think about that?

Mrs Brown—I am certainly not a lawyer but I know that the Constitution gives powers to the Commonwealth government, and this state has its own special legislation with the trade and commerce acts. We have the Nurses Act coming from that. Under those terms, it is probably not impossible but I think it would be extremely difficult to have national registration.

Senator KNOWLES—Do you think it is desirable in principle, though?

Mrs Brown—I guess it depends on what principles it is being based. I do not know that it would be more cost effective.

Senator KNOWLES—Let us say it is based on portability. Someone can go from state to state; they need not worry about registering in other states, even though they might have qualified in Western Australia and want to work in South Australia or vice versa. Is that principle desirable?

Mrs Brown—There is very little inconvenience, if I could put it that way, for people to move from state to state. The Mutual Recognition Act supports health professionals crossing state and territory borders. We ask for a fee to be paid; we ask for identification of the licence where they were practising in the previous state and also that they identify their competency within the particular area. It is a very streamlined process. Once that is undertaken, the person is free to practise within the state. I think that the mutual recognition certainly supports that free movement.

Senator KNOWLES—How long would that process take?

Mrs Brown—It is a matter of application to the board. It has a very quick turnaround.

Senator KNOWLES—Days or workdays?

Mrs Brown—Days. Provided they have documentation of their licensing registration within another state, it is a very quick process.

Senator WEST—You don't have to wait for the board meeting each month to tick it off like you used to?

Mrs Brown—No, that is part of the delegations of authority to the position of CEO/registrar; it is carried out as an administrative role.

Senator WEST—How much paperwork is required, though, as proof of what has gone before?

Mrs Brown—Basically there is only one form that people have to complete. Because we do have very good relationships and communication between the regulating bodies within the states, we are able to get any additional information that is required very conveniently—very easily.

CHAIR—A witness did tell us yesterday that she was waiting to get all this easy process to happen as she moved from South Australia to Queensland. You are in the clear.

Mrs Brown—I was very worried you were going to say something the other way around.

Mrs Cusack—There is a difference between national registration and national regulation. I think it would be very hard to regulate nationally. You need to have an understanding of your local community, particularly related to the interests of the public.

Senator KNOWLES—I agree.

Senator WEST—What about some postgraduate courses, though? We were told yesterday that one place—and I do not know where; it might be here—is looking at six months for midwifery, whereas everywhere else it is 12 months. There is some variation taking place in that, yet it looks as though they can get registration in that state on that six-month course. You have reciprocity across the states. How are you going to maintain standards when you might get some variation within postgraduate courses?

CHAIR—Just before you answer that, can I elaborate on that question? You tell us in your submission on the second last page about the Mutual Recognition Act 1992. My question, subplot A, is: is that a state act or does it require that every state has a mutual recognition act? The submission says that under that act the board is obliged to register or enrol applicants under conditions that are not more onerous than those imposed by the regulatory authority in the state or territory of origin. If a person had done a six-month 'I have never seen a real-life baby'

midwifery course and they get registered in a state which provides such a course and they then come to South Australia, your Mutual Recognition Act would say, 'To do midwifery in this state would be more onerous,' and therefore they could not be registered. Is that the case?

Mrs Brown—It could well be, put in that scenario. However, I think that is the importance of the Australian Nursing Council in the work that they do to make sure that there are consistencies of standards right across the nation. Consistency of standard also looks at the competencies that midwives actually have to have.

CHAIR—That is true, that is what it does. What about the case that Senator West cites: a six-month midwifery course and no need to do deliveries?

Mrs Brown—I am not aware that there is any such course within Australia, from my personal knowledge—

CHAIR—You have not heard of such a course?

Mrs Brown—No, I haven't.

CHAIR—If you had, what would you do? Clearly it would be another state, but what if a person came to you and said, 'I come from state X; I want to come and register in South Australia; I am registered in state X,' and you know they have done a six-month midwifery course and not one delivery? Are you able to register them under your own Mutual Recognition Act terms?

Mrs Brown—That is certainly something that would have to go to the board. The board would have to have a discussion about that. That would be a very isolated case and the board would have to have a decision based on all the information that that person could provide. I would hope it would not come to that. I would hope that the regulatory authorities would have been able, in discussion through the ANCI council, to have understood, in regard to the program that was being offered within the state, that there would be full information given through ANCI to all the state regulating bodies before it actually came to somebody wanting to register with our board.

CHAIR—Nothing on boards is easy, is it, Mrs Brown? I am giving you a hard case.

Mrs Brown—I have found that over the last 12 months, absolutely.

CHAIR—What do you do for the unqualified nursing people, the assistants in nursing or the personal care people? Does the board provide any supervision or regulation for those people?

Mrs Brown—No, under the act the board regulates nursing. The board does not at this stage have a view on the unregulated care worker.

CHAIR—Is anybody putting a view to you?

Mrs Brown—Yes, indeed.

Mrs Cusack—We have received some correspondence from the Australian Nursing Federation. It is also an issue that ANCI have put on their agenda at our request. For us, it is an issue that we have to step through very carefully. It is also an issue for the public in terms of being educated about the different levels of care that are available. So it is one that this board tends to step through very carefully.

CHAIR—Over what period?

Mrs Cusack—I could not give you an answer to that. Again, I think it is something on which we would need to go back to the minister, who we report to under the legislation regarding these discussions.

CHAIR—I guess we will have to leave it there, but it may be that we want to follow that one up. I wanted to ask the department to take on notice a question on agency nurses. How many are being used, in what area, and what is the range of cost differential? We have been told today that sometimes it is a figure of $70. I am not sure whether an agency nurse is getting $70 or the institution is being charged $70, and I therefore ask you to provide for us what percentage the agency keeps and whether that amount of money that you are spending on nurses in the public sector is such that you would consider—I guess that is a question for your minister rather than you, but the Victorian government has actually banned the use of agency nurses in the public sector, to the assessed cost saving of $20 million.

Ms Martin—I can give you an approximate utilisation of agency staff now, if you like.

CHAIR—No, I am afraid we are out of time—I am so sorry. I must unfortunately ask: please can we have on notice that information and the range of fees? I beg your pardon to ask you to do that, because I know it is a bit of trouble.

Ms Martin—That is fine.

CHAIR—Also on notice, would you say if you are still doing overseas advertising and where. If not, you can say no.

Ms Martin—We are exploring some options now.

CHAIR—If there is further information on that, we would be pleased to get it. I am sorry—it is far too interesting—we have run out of time. Thank you very much.

[4.12 p.m.]

IMGRABEN, Ms Susan, DON (Director of Nursing), ACHA Health—Flinders Private Hospital Campus

LEWIS, Mrs Deborah Jane, DON (Western Hospital), ACHA Health

LONG, Dr Leslye Elizabeth, Director of Nursing and Patient Care Services, Royal Adelaide Hospital

McKOY, Mrs Christina, Acting Director of Nursing ACHA Health, Ashford Hospital

RENNIE, Ms Sandra Lynette, Director of Nursing, ACHA, The Memorial Hospital

SILVERSTON, Ms Heidi Joanna, Nursing Director, Administration, Nursing and Patient Care Services, Royal Adelaide Hospital

CHAIR—Before I welcome the witnesses, I place on the record the committee's thanks to the Adelaide Town Hall for the facilities here today. I would also like to put on the record our appreciation of the Mater Misericordiae Hospital in Brisbane yesterday. Both places have been very good in assisting us. Thank you.

I welcome representatives from the Adelaide Community Healthcare Alliance and the Royal Adelaide Hospital nursing executive. 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 we will give consideration to your request. I need to remind you that the evidence given to the committee is protected by parliamentary privilege and that any giving of false or misleading information may constitute a contempt of the Senate. The committee has before it your submissions Nos 900 and 411. Do you wish to make any alterations to those submissions? No. I invite both or all of you to make a brief opening statement and then to field questions.

Mrs Lewis—I would just like to make a comment by way of introduction to advise the committee that Robyn Schubert, who wrote our submission and submitted it on 27 June 2001, was at that time the Group Director of Nursing of what is now known as ACHA Health, which comprises four hospitals and some private commercial businesses in South Australia. Robyn is no longer employed by the organisation, hence the representation from the four directors of nursing. I just wanted to make it known that there has been a change.

I am not sure how much detail you would like from us, but the key recommendations and issues that we have identified are: the need for early recruitment strategies for people who are interested in nursing to enter the profession; the need for a national marketing campaign; the development of student nurse employment; financial incentives both for urban and rural nurses, in particular relocation costs for rural nurses and those sorts things; increased tertiary positions—and we note that it was identified in the report that in South Australia there were applications to the tertiary sector that could not be accepted because of a lack of available placements, in contrast to some of the eastern states; looking at multiple entry and exit points

within the profession so that, if for some reason somebody cannot complete a training program, the training is not wasted and they can perform a useful role within the profession; and the need for labour force planning.

CHAIR—Does anyone else from that group wish to comment?

Ms Imgraben—We are quite comfortable with Deb representing us, and we can answer any questions that are required later.

Dr Long—Royal Adelaide Hospital welcomes this inquiry and appreciates the opportunity to provide input. The current shortages in many of the health care professions, especially in nursing, have the potential to impact on the quality of health care provided. Retention of staff is a major issue for nursing, but also for pharmacy and medicine, and we need to recognise that it is perhaps the health care setting that is suffering these problems, and not only nursing. The enticement of lucrative salaries, both interstate and overseas, poses a risk to South Australia where, in many instances, the salaries afforded to health care workers are lower. The push towards the concept of family friendly employment, whilst laudable, is posing enormous pressure on hospitals, which struggle to cover the family unfriendly days and hours—issues related to providing a 24-hour service. Health professionals are now able to seek alternative positions within health care that are able to meet their requirements; for example, working for drug companies, product companies and community services, and agency work.

Royal Adelaide Hospital believes that the current system of nursing education stifles innovation and progress in the education of nurses and the forming of education and industry partnerships. There should be a closer collaboration of industry with universities in the development of a curriculum that meets service and health care needs. Postgraduate education for registered nurses, where it is undertaken as a partnership, is proving to be a very satisfactory model for all parties. However, the significant university fees for these programs can discourage nurses from pursuing them, particularly if they are from single income families. Royal Adelaide Hospital believes that there is an opportunity for DEST to allocate funding for a discrete number of additional EFTSUs to support partnership innovations in undergraduate nursing education. These could be allocated in a similar way to research funds where a successful proposal for an innovative program would secure placements but be subject to a rigorous evaluation. Some universities currently do not offer nursing programs within their schools of health sciences. We see this as a significant disadvantage and a failure to recognise employment opportunities, the profile of the health care work force and the public responsibility that those institutions have in preparing enough registered nurses to provide a level of care that the majority of Australians pay for through for taxes, expect or require.

Senator KNOWLES—I would like to ask the alliance some questions from the private hospital perspective. We have heard a lot of evidence that private hospital nurses are paid less than those in the public sector. Apart from some flexibilities which are obviously inbuilt into the private sector, what other incentives are there for people to go into the private sector?

Mrs Lewis—What has happened for us is that we have had to match the public sector payment and we have had to keep ahead of the next EB agreement so that we can present that as an advantage to our staff. So we had quite a difficult time last year when our last agreement was negotiated, and we really had no option other than to—

Senator KNOWLES—What other benefits are there of working in the private sector vis-a-vis the public sector?

Ms Rennie—Currently, as an alliance we pay for some of our staff to undergo tertiary courses so we are able to negotiate assistance with fees. We are able to offer to those staff study leave and various other options to continue their career pathway.

CHAIR—Is that across all four of you?

Ms Imgraben—Yes, and just to build on that: what we would have to say is that, if you are looking at the private sector, each organisation or affiliation perhaps looks at staff development and education differently. However, we are not bound by what might be a whole of government initiative that might have to be followed through in the government sector. One of the initiatives we had was the graduate nurses scheme. We secured 60 graduate nurses within the ACHA group, and we had a three-step program where we gave some options to graduate nurses, so they could choose to do their graduate year with us, and there was no charge for that. Then, if they wished to stay with us, in their second year we would fund a graduate diploma of their choice. Then, in their third year, if they had done the graduate diploma in, say, critical care or in a specialty that they wished to, they would do a buddy year with us. So we looked at how graduate nurses may be attracted to having an allegiance to an organisation. I think we have identified that some of the courses are quite expensive for people that are perhaps working reduced hours. We found that to be a good initiative, and I believe that one of the benefits would be that we might have more control of the flexibility of the systems that we can use.

Senator KNOWLES—That is very interesting. I would like to go back to study leave and assistance with postgraduate fees. How far do they extend? How much leave would one be granted, and how much assistance would be offered?

Ms Rennie—Each director of nursing has the ability to approve three hours of study leave per staff member per week. We are currently funding courses of need. For example, if we needed intensive care staff we would offer scholarships, if you like, or assistance or payment of fees for those courses.

Senator KNOWLES—Are people then tied for a length of time?

Ms Rennie—Yes. We ask that they remain for 12 months after the completion of the course at the institution.

Senator KNOWLES—We had evidence a moment ago—I do not think you were here at the time—that was a bit disturbing. It was about the lack of people prepared to go into the operating theatre environment. Are you having that same problem?

Mrs Lewis—I can speak about that as I am quite familiar with that area. At Ashford—I was employed at Ashford for some time before I took up the position at Western—we looked at encouraging students to take up a role within the operating theatres. We did that through a partnership with Flinders University of South Australia, who run a program involving a dedicated education unit where students are placed in a clinical environment for quite significant periods of time. So we started that, and we had students in first, second and third

year that were placed within the perioperative area, and they spent different lengths of time in that area. What was particularly interesting was that the third year group, in their final semester, spent quite a large amount of time there, to the point that they were doing a little bit of weekend work and some late shifts, and we could roster them late, early and that sort of thing so that they got a feel for what the rosters were like to work and what the pressures could be like at different times of the day, and they got a fairly accurate view of what life was like working in a perioperative area. This was very successful for us because many of our surgeons were very encouraging of the students in the area. They understood that there was a need to put a bit of effort into securing the future of the perioperative nurse role. Our senior nurses as well were very keen to support and educate this group of nurses.

The program was actually quite well supported from Flinders University in that there was some training for staff so that they knew what to expect of the students, how to assess them, how to help preceptor them et cetera. There was also a financial incentive for a senior nurse to provide a preceptoring role within the perioperative suite. We did not know how it was going to go—it was the first of its kind in a private hospital in Adelaide. We had overwhelming support for it—and in fact the university was flooded with requests to locate in that area in the next semester. From the third year group we actually retained about three nurses in the graduate nurse program for the following year. With the graduate nurse program, we offered the opportunity for graduate nurses to spend the entire graduate nurse year in that area. Many of them chose to do that and now intend to move into the perioperative graduate program as a result. That has been very successful for us—we found that it worked and really did address many of the issues there.

Ms Imgraben—If I could add to that, taking up the Royal Adelaide's position in regard to being family friendly, a lot of the perioperative work is really around on-call and we have looked at lifestyle choices with nursing if you are working in an acute hospital. We too at Flinders Private followed Ashford's lead in a DEU—dedicated education unit—and again retained two of the third year students that do want to go into a designated program. I think there is that difference in that some of the clinical managers might feel that the nurses should really see what it is like to be a nurse in other areas first. But, looking at the students that are coming out, they have worked in an area and are usually at least 21 to 23, if not mature age. So it is also looking at, if someone knows that this is what they want to do, how we can meet their needs and fast-track their learning in that specialty.

Senator KNOWLES—So when we look at that specialty—in that context in which you have just used the word—are you talking about operating theatre or are you talking about operating theatre for cardiothoracic, orthopaedic, or whatever?

Ms Imgraben—When we use the term 'theatre specialty perioperative', I think it is that whole broad area. However, within that, there would be certain streams that have different complexities associated with them. There again, probably each of us in our own hospitals would know the subspecialties within perioperative nursing that we have difficulty recruiting staff to.

Senator KNOWLES—So you can stream people in by dangling a carrot?

Ms Imgraben—It is also skills. Looking at cardiac surgery, for example, if you talk to recruiters—even from overseas—they will say that certain nurses tend to stay in the same field. It

is highly technical, highly specialised and very stressful at times, so you tend to stay with the surgeons, the support team and the perfusionists that you know once you get to that level.

Senator KNOWLES—The surgeons invariably have their own teams that they prefer, don't they?

Ms Imgraben—Not always. For cardiac surgery, there is definitely a designated team. But generally most hospitals would be looking at some multiskilling when you looking at the higher, acute end of theatre nursing.

Mrs Lewis—There is a bit of variation there. Cardiac surgery is a different skill altogether and stands out on its own, so you would probably have a small group of people that works in that area. Other than that, your mix of work is actually quite complex and, if you are providing an emergency service, there is an imperative to ensure that your staff are skilled in a wide range of clinical specialties.

Senator KNOWLES—Have you all got emergency departments?

Mrs Lewis—No, just Ashford. It depends a little bit on the mix. If it is just an elective hospital, it is probably a bit easier to have a dedicated team, but again it would depend on your staffing levels and the need for agency use. Generally speaking, surgeons like to always see the same face in that room, and they tend to need help to understand that nursing staff need to have leave, get sick and those sorts of things. They need a bit of assistance with that from time to time.

Senator KNOWLES—This might be an unfair question, given that you were not involved in writing this submission, but within the submission there was a suggestion that incentive programs should be introduced to assist with the student retention rate. Over and above what we have just been talking about, which is more to do with postgraduate work, have you got any suggestions about increasing the retention rate?

Ms Imgraben—I think it relates to the students themselves and also to the industry provider. In providing support for speciality training, there is always some preceptorship. Clinical education is very difficult to put a dollar figure on. It is experiential learning. Therefore, we may see traineeships where an industry might get paid a certain levy for taking a learner on. That does not generally happen, apart from the DEUs, where we facilitate students through some upgrading of the salary for a registered nurse to become a clinical nurse. The hospitals are not paid to give the students experiential learning which can, at times, be a costly process.

Mrs Lewis—In the report we have identified that there should be an opportunity for multiple exit points while still retaining employment within the profession. For example, if you start a three year program and for some reason you cannot complete it—and you come out at 18 months—that is not entirely lost and that training can still be used. There may be an opportunity later for that individual to pick that up and develop it further.

Senator KNOWLES—I should probably know the answer to this, but I do not. What happens to the funding for that person if, after 18 months, they decide to go out for whatever reason, and then come back in?

Mrs Lewis—I think that is something for the universities to talk about.

Senator KNOWLES—I just wondered whether you knew.

Mrs Lewis—No, I do not. The other issue with the problem of people starting a course and then not completing it is that something else might appear to be more attractive. They get a foot in the door of a tertiary institution, get started, and then move on to something else. One of the suggestions to try and address that was to employ students and get them involved in the organisations earlier rather than later.

Senator LEES—I want to ask a couple of general questions related to clinical placement. In the Royal Adelaide's submission, and in your opening remarks, you argue that undergraduate nursing programs do not adequately prepare nurses for what they are going to face when they land out there in the ward. Does it matter whether they are in the DEU or whether they are doing block placements? Do you have any opinions on which version of clinical preparation works the best?

Dr Long—We have a disadvantage, I think, with the two universities having absolutely different philosophies. As a large hospital we have to place both groups of students and those two systems conflict, from our point of view.

Senator LEES—They acknowledged that this morning.

Dr Long—I think the DEU is a very sound model and I guess we have had some good feedback from our clinicians about it. However, I still do not believe that the clinical time is adequate for the need so we would want to see more clinical time. It could still be done in the DEU format—or however they do it—but the exposure is not sufficient. One of the concerns for us is the length of the academic year. We believe that that perhaps could be extended and that extension could be the clinical time.

Senator LEES—Could you place them in that extension?

Dr Long—Certainly.

Senator LEES—I ask this of all hospitals. We had an indication this morning that Adelaide University wants to get involved in an undergraduate program. They are doing a feasibility study at the moment. Could you place, say, another 200 students a year?

Mrs McKoy—I think the reality is that if we are looking for staff, we have to accommodate them. If we are saying with our labour force planning that we need that extra 200, I think the onus is on the institutions to facilitate some placement. You cannot learn in a laboratory.

Ms Rennie—But currently the universities do not meet our student numbers. We give each university the number of students we can accommodate. I have never had those numbers met.

Ms Imgraben—I think there is a conflicting need here: the university's need to place students versus the deficits we may wish to fill. Students are not filling deficits within our teams so we are providing experiential learning.

Senator LEES—I would like to go back to Ms Rennie's comments and ask all of you the same question: do you have vacancies right now? With the current numbers that universities already have graduating—it seems about 400 a year in total—do you have places unmet now?

Mrs McKoy—Yes.

Ms Imgraben—I would like to clarify whether that is student places or for employment.

Senator WEST—For student placement.

Senator LEES—We are not arguing about employment now; we are just looking at what happens during clinical placement.

Dr Long—Certainly, if that period of time were more flexible and not so constrained by the university, we would be able to place students differently. But they do constrain us within that 28 weeks, I think it is. It is a very narrow window.

Ms Imgraben—From an adult based learning principle, that could actually mean that we could balance the students rather than have a whole group. The DEU works well with that clinical support, but otherwise it could be quite variable if we are consolidating both universities in a small time frame instead of perhaps being able to strand that out during the year and have different support services in line for them.

Dr Long—There are some universities which are looking at this issue and changing. Certainly, Notre Dame has a sort of boutique program at the moment which is going into its third year and which has an extended period of time and a much larger clinical component. I understand UTS and a number of the other universities in Victoria are looking at it.

Senator LEES—We have struck some universities that are looking at more innovative models, but they tell us that one of the barriers is that a lot of students now need to work in order to fund their university time, and they use those holidays to do extra hours at Kentucky Fried or wherever they are. From the point of view of many of the committee members, it would be a lot better if they spent their time with you as a nurse assistant—

Mrs Lewis—We have started to employ student nurses.

Senator LEES—You have started? That leads to my next question. Can I hear from each of the hospitals whether they are prepared to employ student nurses? If so, please tell me in what role—whether as an enrolled nurse or just as an assistant.

Mrs McKoy—We have developed a three-step competency program. They come in doing basic care such as bed making—the basic needs. Once they complete the competency, demon-

strating safe practice around that, the competency level increases and with that there is a remuneration increase.

Senator LEES—What will be the hourly rate when they begin?

Mrs McKoy—We are negotiating that at the moment, because at the moment I think the miscellaneous workers union and the ANF are having a debate over who this level of worker belongs to. I did a little bit of research and I know the Nurses Board does not recognise them. Our initial thoughts were to bring them in under a nursing award and relate their pay to an enrolled nurse level. From an industrial point of view, we talked to our HR adviser and we have not gone with that model. We have brought them in under an HSE award with a competency program. But, in looking at what some other hospitals are doing, we will probably have to renegotiate the hourly rate that we were starting them off on because it is a market out there and, no matter what you set, if somebody is offering something more you really have to meet it if you want to meet the needs of your staffing establishment.

We did a trial 12 months ago with a couple of students in one ward to pilot what we thought these students might look like. We certainly did not call them nurses; we called them health ancillaries. We did not have them doing direct patient care, although they were making beds. We learnt from that that once they get comfortable in the environment—they are very nervous and anxious when they first start—it is an invaluable learning environment and they become very proficient in what it is that you want them to do. It is really the confidence level that you are building up, so the advantage we see is that, once they become a graduate, you do not have the problems we have now with our new graduates who are unfamiliar with the environment. So we are doing some work on that.

Senator WEST—So you are expecting your graduates to come out at the end of three years, slot into a ward and be able to hit the ground running.

Ms Imgraben—No, I do not think that would be—

Senator WEST—That is the impression that Mrs McKoy left me with after her comments about the third tier. The third tier, I have to say, also sounded like ward assistance, circa 1969-1970, Sydney University, Royal Prince Alfred Hospital.

Mrs McKoy—Same place I trained at.

Senator WEST—Yes, well, probably similar times. It sounded very similar.

Mrs McKoy—Certainly our intent—as you say, these students now work at Hungry Jacks and other places—is to provide them with a learning environment that also assists us. The aim, as I said, as they go through the competencies, is to develop their competency level and, by the time they reach the third competency booklet, they are much more advanced and we are prepared to let them do a lot more than we were are at the beginning. That is safer for the patients and safer for the nurses. We are not there to destroy their confidence. I think you will find, though, that we are all driven by the imperative of the dollar and the nursing hours per patient day that validates care. So, as much as I might say that we want another level worker, in

the private system—I do not know about the public system—the reimbursement is not there from the funding that we get. It is really about trying to maximise your work force.

Ms Silverston—Royal Adelaide Hospital undertook to employ undergraduate nursing students following the ability to do so provided for in the 2001 enterprise agreement. That enabled us to employ people under a specific category of ‘undergraduate nursing student’. We spent a lot of time looking at the difficulty of distinguishing between employment as an undergraduate student and student status, because a number of people who were interested in employment were also students on clinical placement at other times in our institution. So we needed to clearly delineate the two roles. We have employed undergraduate students since towards the end of last year, and the feedback that we have received to date has been very favourable, both from the staff working with the undergraduates and also from the undergraduates themselves, who see this as a fantastic opportunity to learn further about the environment and pick up additional skills in the course of their employment as an undergraduate student.

Senator WEST—I was going to ask about the third tier, but I presume the explanation you have given us is the explanation for that. Royal Adelaide, you want to see more clinical experience; are you wanting to see less theoretical experience?

Dr Long—No, absolutely not, and that is why we are looking at an extension of the semester. What we would like to see is that theory applied to practice—I think there is a gap between the two at the moment. We see that as the way we would be able to overcome that hurdle.

Senator WEST—I notice also that you are really wanting to prepare them for 24-hour service. Not all nursing is 24 hours a day service, is it?

Mrs McKoy—If you are working in an acute institution, like we do, 99 per cent of it is.

Senator WEST—Yes, but not all health care—therefore, nursing care—is acute hospital based, is it?

Mrs McKoy—No, but that is what we are involved in.

Senator WEST—Yes, I know that is what you are involved in, but I am trying to look at the whole gamut of nursing—that is what this committee has got to do.

Dr Long—We would like to see nurses having an appreciation of 24-hour service and to make the choice of what it is that they want to do. Many nurses, when they get married and have families, may not want some of the standard shifts and may want some of those alternatives. It is about exposing them to what is available. Certainly we currently do not employ preregistration students on night duty. However, if one of them wished to work on night duty, we would consider it. We are not trying to prepare nurses for night duty per se; we are trying to introduce them to what it is to be a nurse in the broad sense, so that they then actually make their choices.

Ms Imgraben—If I can just add to that, we talked about specialties. When we look at somebody going through a learning process, some undergraduates say that they would like to do

community nursing or perhaps do some sort of family planning. There are streams that they can go through and we are not always saying that you need to work in an acute care facility—

Senator WEST—Good.

Ms Imgraben—to therefore be one of these people. It is how you have trained to get there. Perhaps in more traditional models people would go through an acute care facility and then perhaps go through to the community. That is also based on the curriculum of their community training or non-acute care hospital training—you are training people for that.

Senator WEST—I hope you are not socialising them into the acute medical model though.

Ms Imgraben—No. But I think we would say that if you wish to work in community health, traditionally, people would go and work in an acute area first then branch out into that.

Senator WEST—They did not have any choice.

Ms Imgraben—That is right. But people who are choosing to go into acute care will need to be prepared for a 24-hour stream and generally there is not a wide range of graduate programs. To the best of my knowledge, they tend to come through the acute care sector for that. I would say that there are minimal graduate nurse programs that ease people from a tertiary centre to clinical practice, be it community or acute care.

Dr Long—I think that the face of our hospitals is changing, and the Royal Adelaide Hospital is probably not really a very accurate reflection. We are actually a Royal Adelaide health service. We have a psychiatric unit, we have rehabilitation and we have community services. So we offer that full gambit to pre-registration students. I think that that has been a change and I do not think it is currently reflected in the titles of many of our institutions; they seem to project an acute care flavour. Certainly, we are able to recognise that some nurses may never want to come through acute settings and our graduate nurse program does offer the opportunity for them to do their graduate nurse program within the range of services we offer. So they do not have to spend the whole 12 months in the acute sector.

Ms Imgraben—And that is also the model of nursing through the continuum of care. We would have nurses working in acute care sectors who would still be very in tune with pre-admission and also easing back into the community. So there is a blurring of the edges around what is acute and perhaps aged care or community, because many roles may work quite closely—

Senator WEST—Where does the control rest? Who makes the decisions? If there is a shortage, from where do the nurses get pulled out first?

Ms Rennie—I can speak for ACHA. Our graduates nominate the areas of choice at their initial interview for placement in our graduate program.

Senator WEST—Yes, but if you turn up on a particular day and you are short four or five and you cannot get any agencies in and you have got that broad range of health services, where do you pull from to put into your acute, if you have to? Or does the acute run as is?

Dr Long—In our institution it runs as is. I do not pull from psychiatric and vice versa, or the community—

Senator WEST—Or the discharge planners.

Dr Long—If we could not staff the hospital, we would probably pull first from our staff development department—our nurse managers, our nursing directors and our staff who are actually involved in non-clinical areas.

Ms Rennie—If necessary, to accommodate the shortages, we actually close beds in units when we are unable to accept more admissions.

Senator WEST—I am glad that is happening!

Ms Imgraben—To support that, when our fiscal year ends, we have to demonstrate that if those roles are assisting us to get people through that continuum of care, that means we are going to have people staying in beds longer. Therefore, in order to function, we need those people who are working in the community and we need to look at people's extended care needs.

Senator WEST—How often do you have to pull back and close beds? How critical is the shortage?

Dr Long—That is very difficult for some hospitals and I have to say that for Royal Adelaide Hospital it is an impossible task. Every hospital goes on diversion, except Royal Adelaide Hospital, so for us to close beds is extremely difficult. However, we do have a small number of beds that we have relocated elsewhere because we have a shortage in our orthopaedic service, which is the only service where we have a bad shortage at the moment. But we still run at the same number of beds, and that is to meet the demands of the emergency workload.

Senator WEST—What has happened to your throughput in the last five or 10 years?

Dr Long—It has continued to increase. It is about six per cent over the targets. That is a target each year which keeps increasing. It is largely in psychiatric and aged care admissions. The information is readily available to all of us; it is just a continuing problem. Despite the fact that we hear that the private hospitals are busier, the work just seems to continue to come through. There has been a significant shift, for our sorts of hospitals, to an emergency workload.

Senator KNOWLES—Do you have any statistics on the number of people coming into your emergency department who should, in fact, be going off to their GP?

Dr Long—That work is happening. Because of the bottlenecks that we have, that sort of scrutiny is happening in the emergency departments now. That work is about to start at the Royal Adelaide Hospital, but I do not have that information at this moment.

Senator KNOWLES—Is there a possibility that we could gain access to information such as that in the near future?

Dr Long—I imagine that there is some work going on around the country which that will arise from, but I am not currently aware of any projects.

Ms Imgraben—There are lots of quality programs through the Australian College of Emergency Medicine, so I would think they would have quite a lot of information with regard to that. That would be in the category of patients presenting to the emergency department.

Mrs McKoy—I can tell you, coming from the other hospital that has an emergency department that, as Leslye has quite rightly pointed out, we go on diversion when we have absolutely no capacity. That is our way of trying to control things. However, it does not control the numbers of people who come off the street. To counteract the number of people who could have gone to a GP, we have a co-payment of $100. Anybody who turns up who does not require admission has to pay $100 out of their pocket that the health funds will not fund. We probably admit 40 per cent of the people who turn up. So, you could say that there are 40 to 45—

CHAIR—Does that save them the $100?

Mrs McKoy—If they require admission, they do not have to pay the $100. It is to stop the GP type presentations.

Senator LEES—But are we not now seeing very few 24-hour clinics across Adelaide and a reduction in the number of doctors? I know the one at Mile End has now pulled back, closing at five o'clock on Saturdays and Sundays. It used to close at 10 o'clock.

Mrs McKoy—The reason we do this is that there is no funding. An emergency department in the private sector receives no funding from the funds.

Senator KNOWLES—How about a GP after hours? In Perth, all these little GP after hours places have popped up in hospitals—St John of God Hospital, St Anne's and all those places.

Ms Rennie—Several of the hospitals have done that. I think the Queen Elizabeth and the Blackwood have. There are trials in place to evaluate the effectiveness of having GPs on site, but I have not read any reports.

CHAIR—Evidence was given to us in other places about the way private hospitals are managing their nursing needs in ICU or theatre by getting nurses who are working part-time in the public hospitals. Is that the case?

Mrs Lewis—No.

Ms Rennie—I can only speak from the Memorial Hospital perspective. I am unaware that I employ staff who currently work at public facilities. However, I do use a large component of agency staff. Those agency staff may well be employees of the government sector, but I am unaware of that because I am not their employer.

Mrs McKoy—We use the agencies if we have a shortfall.

Mrs Lewis—We are not actively employing or recruiting from public hospitals.

CHAIR—Dr Long, can you help us with that? Do you know of any evidence that some of your nurses who are part-time are also working in the high-intensity jobs in the other private hospitals?

Dr Long—I am aware of a couple of nurses who have done that with one of the private hospitals in the cardiac area, with which we have an affiliation. But I think that most of our nurses would go and work for the agency, because they pay better. We have no indication of who they are, because they do not come back to our hospital to work as agency nurses. But, anecdotally, we are aware that that happens.

CHAIR—How many, or what percentage? Can each of you provide for us what percentage of nurses are agency?

Mrs McKoy—Through our recruitment strategies over the last 12 months, we have reduced our agency numbers from about 25 per cent to 15 per cent.

CHAIR—Is that cost, mainly?

Mrs McKoy—Did we reduce it through cost?

CHAIR—No; is it driven down by cost?

Mrs McKoy—No. It is driven down through our recruitment strategies. The aim is to maintain the service.

CHAIR—Why don't you use agency nurses?

Ms Rennie—We have recruited 10 per cent of what we were previously using through agency, so we have been able to reduce that factor by 10 per cent.

CHAIR—Why did you recruit? It just goes round in a circle.

Ms Imgraben—It is fair to say that cost is a significant component. We can significantly demonstrate that we can save money employing staff rather than paying them the higher agency rate. However, there are other factors involved in agency. I have one area in which I can demonstrate that a high agency rate means you do not have consistency with staffing. It could be quite variable. So we would look at it from a customer service and a quality aspect. You have a stable team and use agency staff to fill your sick leave or variance factor for peaks and troughs, rather than them being 15 per cent of a work force in any one ward. Cost is a huge factor, but there are also quality parameters.

Senator LEES—So you would be paying for the extra support you are giving students in employing students by then getting those students to stay with you after they graduate.

Ms Imgraben—Yes. We have diverted the cost. We are looking at recruitment strategies, but also at retention strategies, so that we look after the staff we have so they would like to stay with us and train with us.

CHAIR—Is everybody running 12-hour shifts?

Mrs McKoy—Yes.

Dr Long—No.

CHAIR—Adelaide is not; are all the private hospitals?

Mrs McKoy—In specialised areas: ICU and some HDU beds.

Ms Imgraben—That is primarily on their need. It is a staff choice. It is not compulsory.

CHAIR—Were you following closely how effective people are at the end of a 12-hour shift?

Mrs McKoy—We did a big trial—an implementation and a pilot study—based on satisfaction, tiredness and all sorts of factors. When people had a choice about whether they did it or not, it seemed to be a safe alternative that we have elected to go with.

CHAIR—I must say that, personally, I have a great nervousness about 12-hour shifts, just because they are usually in high-intensity areas and people say, ‘That gives me an extra day off.’ That is not an adequate judgment of whether people are clinically on their toes. It is something that we have to watch very closely. People have fought for a long time—over a century—to make sure people did not have to work those hours. It seems to be a retreat. Is information technology a problem?

Dr Long—We have been very fortunate in the Department of Human Services in this state, in that they have been quite progressive with IT. We have a very good clinical information system for nurses. We are looking at a replacement because it is getting old, but it still meets our needs quite well and is integrated with our rostering system. I think we are quite comfortable, but Heidi might want to speak to that.

Ms Silverston—Our care planning system is Excelcare, which has been around for some 13-odd years. Royal Adelaide was involved in the pilot and the testing of those from fairly early on. We have had those systems in place for quite some time and, as Leslye says, we have been fortunate in being able to maintain those systems.

CHAIR—The time being what it is, I have to close this session because people have to catch planes—to say nothing of you having to go back to workloads and so on. Presumably your own hospitals will cover what your information technology needs are, but I am particularly interested in the training and access to training for—as we heard today—older staff and those people who just dust the computer, as opposed to those young ones whose children use it. I was very pleased to know that there are the dusters and that nursing is ‘what our mothers would do’. I think that is dreadful. But it has been very interesting, what we have learnt today.

Senator WEST—If a 16-year-old is saying nursing is what your mum would do, and you had the child at 20, you are still in your mid-30s, or 40 at most. You still have 20 years left in the work force; you could go and do a nursing qualification.

CHAIR—Absolutely. It also means you know how to dust, at least if you go on today's information. I wondered if there was anything further you would offer. If you do not have anything special to say, please do not feel driven to do so. We have to finish. Thank you very much indeed for a very useful session.

[5.00 p.m.]

MUDGE, Lieutenant Mark Anthony, Private Capacity

CHAIR—We should include this information in *Hansard*. Lieutenant Mudge, for the record, can you give us your name and the capacity in which you have been here today?

Lt Mudge—My name is Mark Mudge. I am a lieutenant in the Australian Defence Force, regimental number 4801502. I have come today in the capacity of an observer. When I worked for the nurses board, I helped prepare the brief that you heard today. My current employer rang me this morning and asked if I would come along and listen, and that is why I am here.

CHAIR—Thank you very much for that. We had observed that you were down there and, having discovered that your history is very full of very relevant nursing information, we hoped we would have time to get you on the record. I guess we have you on the record, but we do not have time to do anything further. If you would like, in the light of what you have heard today, to drop us a small submission, we would be pleased to get it. I do not push you to do that if you do not wish to. If you do, you can just make some dot points or comments. We would be very pleased to get that if you would like to do it.

Lt Mudge—I will definitely do that because, having listened to everything you have heard today, I think you have an extremely conservative view of nursing in South Australia. There are many questions I could have answered along the way that I will most definitely put in a submission to you.

Senator LEES—Please feel free to pick out the questions and give us the answers.

Senator WEST—Please feel free to encourage the Surgeon-General to do so also.

CHAIR—Now that you are on the record, Lieutenant, you will be eligible for a copy of the *Hansard*, which may also assist if your notes were not 100 per cent copious. Thank you very much indeed.

Committee adjourned at 5.02 p.m.