

## Outline of proposals from the Career Structure Review

This Paper outlines the proposals and main issues arising from the review of the nursing and midwifery career structure. A revised Career Structure will form the basis for Enterprise Bargaining negotiations for public sector nurses and midwives in South Australia in 2007.

Copies of this paper and further working papers from the Review are available at: [www.nursingsa.com/prof\\_career.php](http://www.nursingsa.com/prof_career.php)

We welcome your comments and feedback on the proposals – use the online survey on the website to send in your responses.

### Introduction

A Nursing/Midwifery Career Structure has several purposes – improving organisational capacity by fully utilising nursing/midwifery roles; improving clinical effectiveness and patient outcomes; and providing a professional basis for the salaries and work conditions of nurses and midwives.

The proposals in this paper are based on the expressed wishes and perceptions of nurses and midwives and information from a range of contemporary sources and literature.

**The proposals in this Paper are under discussion and no agreements have yet been reached by the industrial parties.**

### Grouping of types of roles

This paper refers to three main groups of roles – clinical, management and functional.

‘Clinical’ roles or activities may include care delivered to a single person or groups of people, or to a community. This group of roles includes a wide range of practice models and philosophies of care. These may vary from wellness and recovery approaches to palliative care models.

The term ‘Service Delivery’ refers to the organisational mechanisms for delivering health services, including nursing and midwifery care.

For example, administering medication and observing its effect is part of nursing and midwifery practice. Ordering the medications, getting them to the delivery point, etc is a service delivery issue.

Management roles might refer to managing the service delivery – such as managing a ward or service – or to managing staff and resources.

The term ‘functional’ is used in this paper to group together roles that support nursing/midwifery clinical practice but are not clinical or line management roles.

The most common role in the ‘functional’ grouping is education. Other roles include quality assurance, health informatics, research, new roles such as practice development, and some non supervisory management roles.

Deciding what terms to use is one of the issues on which the Review Project is seeking feedback.

The detail associated with these proposals is currently being explored further and your feedback will assist this process.

Final details and associated wages and conditions will be determined within the EB process in 2007.

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### Current Nursing/Midwifery Career Structure

<b>Exe.</b>	Directors of Nursing Services (large hospitals, some with regional responsibilities)
<b>Level 5</b>	Directors of Nursing Services; some EO/DONs; some CEO/DONs
<b>Level 4</b>	Nursing/Midwifery Directors: Management OR Clinical Division OR Functional Department
<b>Level 3</b>	Nurse/Midwife Managers OR Clinical Nurse/Midwife Consultants OR Nurse/Midwife Educators AND some Clinical Nurse/Midwife Managers, project, liaison, support roles AND some Designated Nurses, and Nurse Practitioners
<b>Level 2</b>	Clinical Nurses/Midwives and some Designated Nurses and Project Nurses
<b>Level 1</b>	Registered Nurses/Midwives (Y1–9) Enrolled Nurses Undergraduate Student Nurse/ EN Cadet

### Proposed Nursing and Midwifery Career Structure

<b>Grade H/I</b>	DON and Nursing/Midwifery management roles in Facilities (Hospitals), Divisions, Functional Departments, Regional, Clinical Network Liaison positions (numbers and spans of roles to be clarified in EB negotiations) Plus some Professional Leader roles to co-ordinate standards across Nursing/Midwifery Clinical Practice roles		
<b>Grade G</b>	Nursing/Midwifery Clinical Services Co-ordinator	OR	Nurse/Midwife Clinical Consultant
		OR	Nursing/Midwifery Educator or Other Support Roles
	(Reclassification criteria apply here)		
<b>Grade F</b>	Nursing/Midwifery Clinical Services Co-ordinator	OR	Nurse/Midwife Clinical Consultant
		OR	Nursing/Midwifery Educator or Other Support Roles
<b>Grade E</b>	Clinical Nurse/Midwife (with some functional or management activities in dedicated time) (Reclassification criteria apply here)		
<b>Grade D</b>	Registered Nurse/Midwife		
<b>Grade C</b>	Advanced Enrolled Nurse		
<b>Grade B</b>	Enrolled Nurse		
<b>Grade A</b>	Undergraduate Student Nurse/ Midwife and EN Cadet		

Types of Roles: **Clinical / Clinical/management mix / Management / Functional**

### Level 1 and Level 2 roles

The majority of nurses/midwives are classified at Level 1 in one of nine annual increments. The Clinical Nurse/Midwife role (Level 2) has 4 increments.

In the original Career Structure proposal 20 years ago, there were to be sufficient Level 2 positions per ward/unit to allow those roles to form a leadership team to support the leadership role of the CNC.

This did not occur and Level 2 position numbers were limited. As a result, there has never been a sufficiently robust associate leadership structure to provide support to CNC/CMC roles and to provide clinical leadership to Level 1 nurses/midwives, ENs, and students.

The review has considered a number of issues:

- the expressed wishes of many nurses/midwives to remain ‘at the bedside’ as clinicians but be rewarded for increased or advanced skills and knowledge
- the expressed need of organisations for more advanced clinicians across the hours of the day and days of the week
- the need for an associate leadership role to support and sustain the ward/unit’s service goals and practice standards
- the many functional activities that have been added to these roles and which compete with clinical care time or are undertaken in unpaid overtime or personal time

### Proposed Role Changes

The proposals from the Career Structure Review are set out here in order of current levels.

#### Advanced Enrolled Nurse role

Enrolled Nurses provide nursing care in a variety of settings, under the direction and supervision of a Registered Nurse.

These roles mainly focus on general and specialised procedural activities involving manual and technical work and interpersonal skills. Role activities may be varied and depend on patient needs, the setting and the level of competence of the Enrolled Nurse.

The current EN progression to the highest pay point occurs by having education recognised. Additions to

EN activities currently occur, or are prevented, according to local informal arrangements. More consistency and an opportunity for ENs to obtain a promotional position are envisaged.

**Proposal:** That a new concept and role of Advanced Enrolled Nurse be implemented.

This position would be appointed within defined circumstances, and appointed to act as a resource for, and provide leadership to, other Enrolled Nurses.

These roles would continue to focus on general and specialised procedural activities. However, the advanced EN would be expected to make more substantial contributions to the clinical decision making of RNs, and/or to demonstrate higher level evaluative skills, and to hold an Advanced Diploma in Enrolled Nursing or equivalent.

- the lack of career progression opportunities for most nurses/midwives
- the need for more workplace based learning opportunities to enable nurses/midwives to keep up with frequent changes to techniques, equipment, clinical knowledge, and management systems, and
- strategies that are likely to have an impact on improving recruitment and retention.

**Proposal:** That a new concept of Level 2 roles be implemented.

These roles would recognise the advanced levels of clinical decision making, therapeutic relationships, procedural activities and technical skills provided by RN/RMs who have developed their practice through learning and experience.



These roles would also provide active contribution to service outcomes through a variety of 'functional activities' (see below) but the roles would remain predominantly clinical.

These new Clinical Nurse/Midwife roles would mainly be achieved by means of reclassification.

Earliest application would be following three years experience as RN/RM, but one could apply at any later point of experience. Annual re-application is NOT proposed.

Proposed criteria for reclassification to this level include demonstration of:

- consistent provision of high quality culturally sensitive nursing/midwifery care in partnership with patients, and other members of the multidisciplinary care team
- acceptance of accountability for own actions and insight to seek guidance appropriately
- the application of critical thinking, analysis and problem solving skills, and
- active participation in orientation, preceptorship and mentoring of new staff and students.

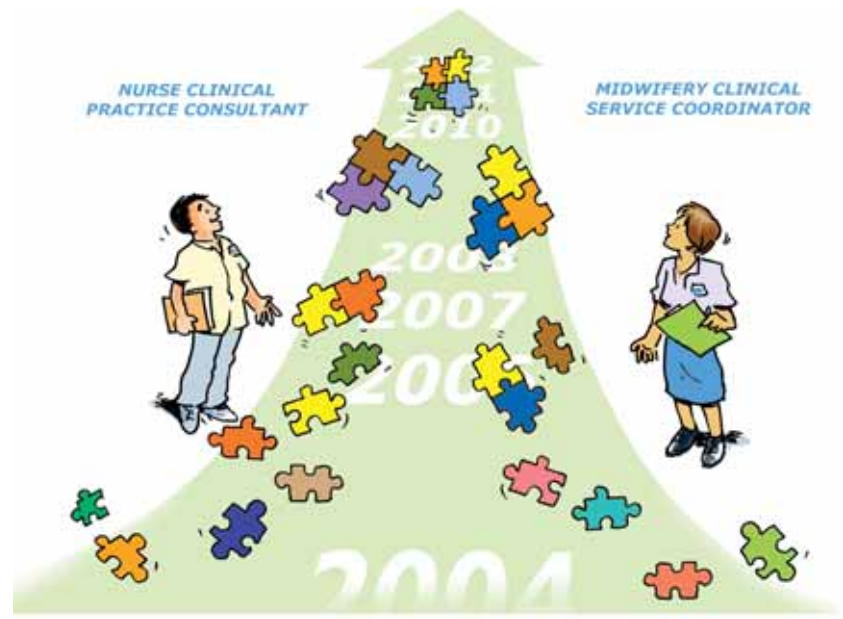
Documented evidence could be provided using a 360 degree feedback and/or performance development review undertaken according to agreed organisational criteria and processes.

A final criteria would involve assessed formal learning experiences. Further detail needs to be determined, but it is proposed that learning outcomes equivalent to Graduate Certificate or Diploma levels of education would be suitable, although achievement of such learning might occur in a variety of ways.

It is proposed that the process for reclassification be based on principles of consistency, transparent decision making processes and clearly identified ways of addressing criteria.

It is proposed that successful entry into this level would result in some acceleration of pay points at the point of entry.

In this 'second level' – within a job description with advanced clinical care expectations – the option of taking up various 'functional activities' would be available. These 'functional activities' could include clinical teaching (in the work area rather than a classroom), research activities, quality audits, local rostering, managing specialised equipment or providing support for



ongoing projects such as Infection Control or updating of clinical procedures.

'Appointments' to a particular 'functional activity' (within the advanced clinical level) might occur annually, using internal selection processes, and providing a 'performance agreement' for the period of appointment.

For example, the area might require a nurse appointed for 2 days per week of clinical teaching. The 'performance agreement' would outline a specific number of sessions or a specific number of nursing staff, certain listed skills, etc to be achieved. The nurse would be required to provide a report at the conclusion of the appointment period indicating outcomes met.

**From The Future**

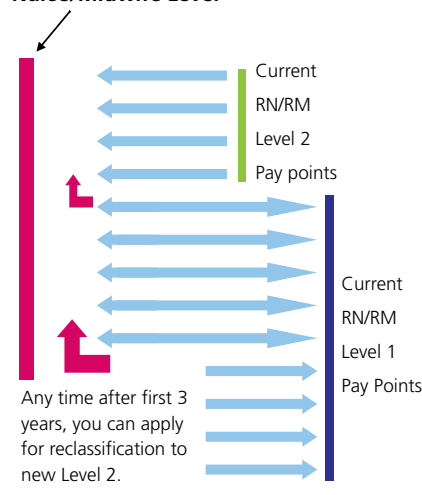
In 2015 a nurse and a midwife were talking about their career paths.

In 1990 Simone became an EN. Later she did RN and RM courses and then became a midwife in 2004. While working as a midwife, Simone was a quality auditor 1 day a week for a year, and then from 2008 she did the unit rosters for 2 years. She combined this with her labour ward shifts by having one week in four dedicated to rostering activity and working with the Hospital's Level 3 Rostering Manager. In 2011, Simone successfully became a Level 3 – managing the Labour Ward and Birthing Unit.

In 2007, after 7 years as an RN, Luke decided to go for a reclassification to Level 2. This was successful and in 2008 Luke took on clinical teaching activities for 12 months. He worked 2 shifts a week in the medical ward and 2 shifts a week teaching nurses on his floor. On the other 3 days he went fishing. During 2010, Luke worked 5 days a week, doing 2 days a week with the Clinical Procedure Review Team, updating procedures for the Country Health Regional Manual. In 2012, Luke successfully became a Level 3 Practice Consultant based with two others looking after complex chronic respiratory clients through a nurse led clinic and a home nursing team.

Undertaking some "functional and management activities" in conjunction with their clinical roles allowed Luke and Simone to develop some of the skills and knowledge needed for further promotion to Level 3.

**Proposed new Clinical Nurse/Midwife Level**



It is not proposed to pay additional allowances for these 'functional activities' – to do so would be to reinforce current inequity in rewarding roles other than clinical care with higher salaries.

The key issue raised in feedback to the Review is that these activities need allocated time so that clinical care time is not compromised and unpaid time is not used to achieve them.

In addition, the importance of ensuring time for clinical teaching and learning will be emphasised for this level and for Level 3 roles in all settings. The Review proposes that clinical teaching be recognised as an integral part of nursing and midwifery practice.

It is proposed that sufficient 'associate leadership' roles are allocated to allow continuity of the ward/unit leadership team across all days of the week and most times of the day.

'Associate leaders' could be appointed from any nurses/midwives who have been reclassified into the advanced clinical role at current Level 2 pay points.

Other nurses/midwives could continue into the current Level 2 pay points by having completed a defined period in a 'functional activity' (or defined equivalent) and completing usual performance review processes. It is proposed that the process of moving into these pay points be a cost effective administrative process.

For example the CHRIS system can identify that a recent performance review has occurred and can identify time spent in 'functional activity appointments'.

Current Level 2 nurses/midwives may have increased opportunities for promotion with the proposed changes to Level 3 roles outlined in the next section.

### Level 3 roles

Nurses/midwives perceive that many changes in role content of these positions have occurred.

Clinical Nurse/Midwife Consultants have become predominantly operational managers of ward areas rather than mainly working as expert clinicians. The roles are based on geographical units not on patient or client groups.

Nurse/Midwife Managers have had to take on work coming from overloaded Level 4 roles and in many sites rostering

and equipment management have been moved back to CNCs/CMCs.

In many organisations these role changes have been further confirmed by the combination of roles into Clinical Nurse/Midwifery Manager roles, often with simultaneous reduction of role numbers.

In addition Regionalisation has brought discussion about centralising some Human Resource Management activities. However, it is not clear how the face to face side of HR might be affected.

Increased computerisation of procedures has changed decision making processes and increased data entry work in all roles but particularly for Nurse/Midwife Managers.

New positions have been developed to accommodate care redesign and to achieve improvements to continuity of care and patient pathways.

The original third stream was nursing education but now there are a range of functional roles supporting practice.

Some academic and research roles have been funded but these have been located in university departments or research organisations rather than being clearly placed in health care organisations.

There is an increased need for Level 3 roles to provide conflict resolution, counselling, mentoring and team leadership in highly pressurised environments.

Increased level 3 role expectations and workloads have generally not been accompanied by additional resources for more roles or more support to enact roles fully and efficiently.

**Proposal:** It is proposed that the work of all current Level 3 roles be translated into roles in one of three groups.

The first of these groups of roles would focus on operational management of nursing/midwifery services.

The work in these roles may not be very different from the way some Clinical Nurse/Midwife Manager roles or some CNC/CMC roles are currently enacted. The key difference is made by the creation of the Nursing/Midwifery Clinical Practice Consultant role in addition to realigning present roles.

### Nurse/Midwife Clinical Service Co-ordinators

These roles would provide nursing/midwifery service delivery management in a defined ward/unit to achieve local outcomes consistent with clinical and organisational performance measures.

These roles would focus on

- day to day operational issues in the area
- general clinical care standards for patients
- management of local staffing, supplies, equipment and cost centre budgets to achieve service delivery benchmarks, and
- local service quality improvement and evaluative research activities within a risk management framework.

The roles would use advanced clinical knowledge and skills and work collaboratively with Clinical Practice Consultants to integrate their input into the care of patients in the ward.

Following research on roles in NSW, it is anticipated that at least 70% of such roles would consist of activities clearly identified as operational management.

The second of these groups of roles would have a clinical expert focus (ranging from direct care expertise to managing transitions of patients between inpatient and community/home services).

It is proposed that additional roles be developed in this group to support the implementation of clinical networks and care redesign activities. Such new roles would provide increased promotional opportunities for current Level 2 nurses with developing expertise in their practice areas.

### Nursing/ Midwifery Clinical Practice Consultants

These roles would provide clinical leadership and advanced level nursing or midwifery care in conjunction with developing and supporting care delivered by registered and enrolled nurses or midwives.

These roles would focus on providing expert input into assessment and interventions.



In addition they would undertake clinical risk minimisation and outcomes evaluation/practice research in their area of work.

These roles may involve providing advice to nurses or midwives in service teams and/or making clinical intervention decisions and/or referrals about the care of an individual or group of patients; liaising between treating teams and GP practice or home or community care; undertaking clinics for assessment, diagnostic, treatment or follow up purposes; providing direct individual or group care in inpatient or community settings; and providing clinical supervision.

Some incumbents of these roles may be Nurse Practitioners.

The manner in which the clinical care workload of Nursing/ Midwifery Clinical Practice Consultants would be measured needs further discussion.

It is anticipated that at least 70% of such roles would consist of activities clearly identified as clinical practice.

The third of these groups of roles would focus on specific functional services to support clinical practice or service delivery.

### Nursing/Midwifery Clinical Support Facilitators

These roles would draw on an additional discipline's knowledge and skills to provide a functional support service.

### Nurse/Midwife Educators

The most common roles would provide educational services including learning experiences in various delivery modes, academic teaching, provision of educational materials and development and professional oversight to clinicians undertaking clinical teaching activities.

### Other roles

These would include health informatics; clinical information support; research, project and practice development roles; organisational level support of nursing /midwifery quality activities and/or management activities.

It is anticipated that at least 70% of such roles would consist of activities clearly identified as belonging to the relevant function of the role.

It is also proposed that there be a second grade available for each of these role groups. This higher grade might be attained by appointment or reclassification.

A critique of the current 'banding' system has highlighted that some criteria, while useful for one type of work are irrelevant for another, and thus reclassification criteria need to be more closely matched to the type of work in the role.

For example, span of control involving staff numbers and budget amounts may be useful in differentiating levels of management work.

However in clinical work, higher classification levels may relate more to the exercise of independently determined treatment interventions, setting systems precedents for clinical care, or perhaps the degree of pro-activity required in intervening in a patient's care.

It is proposed that reclassification or appointment criteria for these roles be made specific for the different types of roles.

## Level 4 and 5 roles

Nurses and midwives working in Level 4 and 5 roles have also experienced significant work intensification. These roles are supposed to average 38 hours per week. However, the 'no fixed hours' clause and lack of paid overtime, on call, or recall allowances for most of these roles mean that the amount of time actually worked is not clear.

Feedback indicates that average weekly working hours are well beyond the 38 hour mark.

There appear to be no workload measurement processes to indicate what a reasonable workload would be at these levels. Lack of administrative support for Level 3–5 roles compounds both the workloads and the redirection of time in these positions.

The 1986 Career Structure largely assumed that Level 4 and 5 roles would manage nursing and midwifery services and associated staff. In 2006, it would be hard to find a role limited to that scope. Most DONs (Level 5) are responsible for a range of other services and staff in the organisation. Most Nursing/Midwifery Directors (Level 4) similarly have responsibility for a range

of other services and staff in a clinical division, in conjunction with Medical Directors who are often only sessional in the management role.

**Proposal:** It is proposed that the span of responsibility, and administration and project support needs, of Level 4/5 roles be examined as part of determining the number and nature of positions required.

It is proposed that new concepts of Regions, Facilities and Services require new definitions for the EB Agreement.

In terms of proposed roles at these levels, the following activities may be included:

- provision of executive level professional advice
- representing nursing and midwifery at executive levels
- influencing nursing and midwifery service delivery within, between and/or across primary, secondary and tertiary settings
- providing strategic direction for nursing and midwifery service systems and performance measures
- putting systems and/or service designs into operational effect for consistent and sustainable outcomes
- balancing strategic and operational perspectives in integrating local nursing and midwifery operations within broader health outcome and service delivery goals
- developing and maintaining working environments that positively influence patient outcomes and nurse/midwife satisfaction indicators.

Some roles at these levels could be sessional in combination with a portfolio responsibility.

It is proposed that some 'fully clinical' roles be developed within these levels to provide appropriate classifications for professional leadership in terms of:

- sustaining consistent nursing or midwifery standards of practice by expert nurses and midwives
- providing nursing or midwifery representation in Clinical Network or Clinical Senate environments
- acting as lead clinicians in planning of clinical reforms
- developing and sustaining state-wide clinical research and practice frameworks.

During the Review some concerns were raised about how the role of providing executive nursing/midwifery leadership at regional/network level.

The Review proposes that the issue of Regional, Executive Officer/ DON and CEO/DON roles is considered in EB negotiations.

### Roles in the Community

Nursing and Midwifery 'in the community' include a range of roles such as acute care in the home, outreach visiting services from inpatient treatment teams, primary assessment, treatment and follow up services, acute interventions, midwifery care, preventative programs for well populations such as school children, babies, supporting self management models for people with chronic diseases groups, and primary health care and community development programs based on social health models.

The emphasis of the Career Structure is on classifications of roles rather than models of care or philosophical approaches to care.

In the Career Structure many community roles would thus be seen to come within the advanced and expert clinical practice classifications – although it is anticipated that local position titles would be maintained in line with service needs.

Thus roles such as Community Mental Health Nurses, Community Development nurses, Diabetes Educators, Well Aged Program Managers, and Midwife – disparate as they are – may share a classification level.

**Proposal:** A reconsideration of allocation of clinical, functional and service delivery or team leader roles in community settings is proposed. This process should include consideration of the need for entry level and advanced level nursing roles, in addition to sufficient expert level roles to fulfil service delivery requirements.

It is anticipated that review of work roles may find that some community roles would need to be reclassified from Level 2 to Level 3 if the work undertaken meets new role definitions.

### Roles in the Country

Consultation with country nurses and midwives during the Review identified that the application of career structure roles required specific tailoring to address

the differences in regional and rural settings in comparison with metropolitan settings.

It is anticipated that the current restructuring of services into a new Country Health SA Region will assist an improved implementation of the new classifications and roles.

**Proposal:** A reconsideration of allocation of roles in country settings is proposed. This process should include consideration of the need for entry level and advanced level nursing roles.

In addition there needs to be a sufficient number of appropriately located expert level roles, to address the need for clinical expertise support for nurses and midwives isolated from the forms of networks and collegial advice that is more readily available in metropolitan settings.

It is anticipated that review of work roles may find that some country roles would need to be reclassified from Level 2 to Level 3 if the work undertaken meets new role definitions.

## Additional Proposals

In addition to issues and proposals directly linked to role levels in the current structure, there are other general issues that were addressed.

### Midwifery

The emphasis of the Career Structure is on classifications of roles rather than models of care or philosophical approaches to care.

In the Career Structure many midwifery roles would thus be seen to come within the beginning, advanced and expert clinical practice classifications although local role titles and models of midwifery practice would continue to be used.

This does not negate the autonomy of the midwife (see later notes on autonomy), but recognises that professional practice ability increases with the additional knowledge and skill derived from experience and further study.

The concepts of educational preparation to work in specific areas and the development of professional practice standards, networks and continuing education are not affected by the Review's outcomes.

**Proposal:** It is proposed that appropriate Midwifery roles and titles continue to be available in the relevant work settings and that Midwifery models such as Caseload Midwifery continue to be supported.

### Promotional positions and part time hours

**Proposal:** It is proposed that promotional roles (at the equivalent of current Levels 2, 3 and 4) be available in flexible hour configurations including part-time.

It is proposed that the allocation of promotional roles equivalent to current Level 2, 3 and 4 roles be based on the number of hours of work required of such roles, rather than a limited number of positions. For example, if a workload measurement process indicates that an average of 134 hours per week of service management work is needed in a certain site, then more flexible structures than 3 full time positions (average 114 hours per week) should be implemented.

A study of 643 nurses in the NHS indicated that there was no significant difference between part time and full time nurses in terms of reasons for working as nurses, nor in the balance between desire to provide a service and desire to have a career.

The study also reported that although no formal policies prevented part-timers from working in higher grades, informally it was general practice not to do so and that usually these grades were advertised as full time, excluding others from applying.

It is proposed that the EB negotiations address the issue of availability of part time promotional roles.

### Nurse Practitioners

Respondents to surveys conveyed opposing views on the relative classification levels suitable for Nurse Practitioners.

Some nurses believe that if clinical positions are achieved at Level 4 then all Nurse Practitioners should be classified at that level.

Some nurses believe that since Nurse Practitioners have no staff, budgets or line management responsibility, they should be classified at a lower level than management roles.

The Review takes the position that the decision making and accountability



of expert clinical roles such as Nurse Practitioners is different to, but equivalent to, the responsibilities and accountabilities of management roles.

However, the Review also takes the view that the Nurse Practitioner role is not necessarily the only form of expert nursing role.

**Proposal:** It is proposed that for salary classification purposes the roles undertaken by Nurse Practitioners are considered on the basis of their work role rather than the regulation requirements of the role.

## Support issues

During the Review there was significant feedback calling for appropriate financial and infrastructure support to allow nurses to practise their appointed roles to their full capacity.

A key example was the request for increased hours of clerical support at ward level, in community teams, in country hospitals, and for nurses in management roles. Examples of inappropriate use of nursing time and diverted expertise were given.

A second group of examples identified the need to examine how nurses are used to cover reductions in services of other departments. Examples included nurses undertaking collection of goods, stores replacement, moving of equipment as wards closed and opened, and the regular addition of allied health activities after office hours.

Feedback supported the introduction of workers such as allied health assistants. Such roles could undertake the after hours activities such as routine passive movement, mobilisation and chest exercises that nurses currently have added to their work.

In addition to the impact these activities have on reducing the time available for nursing, there is concern about the impact of nursing budgets effectively covering work of other departments and contributing to false impressions of nursing costs.

**Proposal:** It is proposed that the impact of levels of support roles be considered during negotiations about nursing and midwifery role allocations.

## Implementation issues

The implementation of new roles will be undertaken using standard translation rules to align current roles with new roles and process movement of nurses and midwives to new roles.

Educational support will be required to skill some people in new portions of their roles and to clarify the implications of role changes.

It is proposed that an implementation strategy be developed and enacted for at least six months following the implementation date in 2007.

## Industrial Issues

Some of the issues raised through feedback and consultation relate directly to wages and work conditions.

The most prominent concern is that the 'gap' between Level 1 and 2 and Level 3 pay and conditions (loss of shift allowances, decreased annual leave, and loss of PDOs) is not large enough and is perceived as a major dissatisfier in Level 3 roles

Concerns about the difficulty of having award/agreement conditions fully implemented were raised by some nurses and midwives.

These concerns included management refusal to grant earned TOIL and the low levels, in practice, of paid release time for study and continuing education.

**Proposal:** It is proposed that Review feedback relating to wages and work conditions be forwarded to the industrial parties for consideration in the EB negotiating process.

## Ideas not supported by the Review

Some issues and proposals raised by respondents were not supported by the Review.

## Pay for better performance

Many respondents suggested that classification levels should be based on the performance quality of an individual.

Respondents called for rewards for clinical nursing excellence, the ability of the

nurse, promotion based on performance and not a fixed number at each level and rewards for exceptional nursing.

In the Review process considerable attention was given to such proposals including attempts to develop a detailed matrix of 'levels of applied knowledge, skill and attitude' across a range of elements.

In industrial terms such a classification structure is termed 'performance based pay'. In the end, classifications based on performance levels were rejected by the Review.

Reasons included the difficulty in establishing effective and efficient assessment processes and difficulty prescribing criteria that would sufficiently and definitively differentiate individual performance within team professions such as nursing and midwifery. The likelihood of under or over classifying individuals and of classifications moving up or down according to perceived changes in performance were also factors in the decision.

In addition it was recognised that the ability to recruit and retain staff due to competition between jurisdictions could potentially be affected by a 'pay for performance' system.

## Pay for more or new tasks

A work role is made up of many activities. A clinical role may include some administrative and functional tasks as part of delivering care, but overall the role remains a clinical one.

The type of tasks or activities in a role will change according to new techniques, work arrangements and technical inventions. However the fundamental roles do not change simply because some of the activities do.

Some respondents to the surveys wanted additional pay for additional tasks, especially if these were thought to be 'medical tasks' – such as IV cannulation. However the Review sees this to be more a minor change within a role rather than a role in itself.

There was a suggestion that ICU nurses who attend cardiac arrests in ward areas somehow became responsible for these patients and thus had an expanded role. However the Review again considered the undertaking of irregular tasks – no matter how acute or specialised – as not forming sufficient focus to influence classification levels.

## Basing classification on autonomy

Registered nurses and midwives are accountable for their clinical decision making and have moral and legal obligations for the provision of safe and competent nursing/midwifery care, including an ethical responsibility to report instances of unsafe and unethical practice.

It is not well understood by the community, nor perhaps by medical doctors and healthcare managers, that nurses and midwives are not passive implementers of medical practitioners' orders, and do not work under medical supervision. Nurses and midwives hold direct legal and ethical accountability for their clinical practices and that of their colleagues.

Thus all RNs and RMs are regarded legally as autonomous health professionals.

However, it is true that in some organisations there are limitations placed on the practice of nurses and midwives and thus the ability to exercise one's autonomy can be decreased.

To use autonomy as a major criteria for classification purposes may result in artificial or arbitrary restrictions being placed on classification levels.

## Contracts at Level 2, 3 and 4

Some nurses and midwives suggested that Level 2 and 3 and 4 positions be contract positions to ensure that people who were perceived as not performing to the expectations of the role could be removed from the position.

The Review took the position that not keeping up to date or not enacting a role at the performance levels expected is a management rather than a career structure issue. Also, the use of short term contracts does not necessarily address performance issues but may simply move a person to another area.

Performance development processes should be used to identify and address failure to meet performance expectations and failure to maintain currency of knowledge, skills and competencies.

## Classification of specialist

No classifications or titles of 'specialist' have been included in the Review proposals. The previous 'nurse specialist' title and classification process was introduced to try to better reward advanced practice. This will now occur through the proposed changes at Level 1 and 2.

A speciality has been described in the Review as a nurse's 'post code' – the place or setting of work rather than a level of work for classification purposes.

The emphasis of the Career Structure is on classifications of roles rather than models of care or philosophical approaches to care.

In the Career Structure many specialist roles would thus be seen to come within the advanced and expert clinical practice classifications.

The concepts of educational preparation to work in specific areas and the development of professional practice standards, networks and continuing education are not affected by the Review's outcomes.

The position taken in the Review reflects the increasing need of the health care system for flexibility across specialties, multi specialties and roles that assist health care users to navigate across and between medical specialties.

## Next Steps

During the period from December 2006 to Friday 19th January 2007 feedback on these proposals can be given to the Department of Health Nursing Office and to ANF (SA Branch).

During this time, further work will occur on the details related to the proposals, role allocation mechanisms and implementation issues.

From early 2007, the Career Structure proposals will become part of the Enterprise Bargaining process.

At that time the wages and industrial conditions attached to nursing and midwifery roles will be negotiated.

Implementation of both the new career structure and new wages and conditions will occur from July 2007.

## How to have your say on the Review proposals

### YOU CAN

Respond to the feedback questions on the Career Structure web page at

[www.nursingsa.com/prof\\_career.php](http://www.nursingsa.com/prof_career.php)

or

### YOU CAN

Provide feedback to ANF via worksite meetings or in the Career Structure section of their website at

[www.sa.anf.org.au](http://www.sa.anf.org.au)

**As several nurses observed during the Review – the current career structure is familiar and so it may seem better than change – but is it really?**

**Have your say as Nursing and Midwifery look to the future.**

## Comments close 19th January

### For further information contact:

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