



CAREER STRUCTURE – Survey One: Context

Feedback as of 8 December 2006

576 people have accessed the survey and 358 people answered

Roles classification	
EN	7%
RN 1 or 2	31%
RM 1 or 2	10%
RMHN 1 or 2	7%
Level 3 and above	43%
Other	2%

Main type of work	
Clinical practice - general	43%
Clinical practice –midwifery	9%
Clinical practice – mental health	11%
Management/Administration	22%
Education/Research	13%
Student	2%

Work location	
Country	20%
Regional city	7%
Metropolitan	73%

Work setting	
Hospital	83%
Community	17%

Generation	
Matures	4%
Baby Boomers	63%
Generation X	29%
Millenials	4%

Do you think it is important for a new career structure to:	Very Important	Important	Not very Important	Not Important At All	Not Sure
Support effective and efficient delivery of nursing/midwifery care?	86%	12.5%	0.5%	0.3%	0.7%
Support nurses/midwives practising to their full capacity?	85%	14%	0.5%	0.5%	-
Increase the diversity of available nursing or midwifery roles?	59%	35%	5%	0.5%	0.5%
Provide more flexibility of movement between different roles?	52%	40%	6%	0.5%	1.5%

Do you think it is important for anew career structure to include roles that assist nurses and midwives?	Very Important	Important	Not very Important	Not Important At All	Not Sure
To reflect on and improve their practice?	66%	31%	2%	0.7%	0.3%
To deal with the risks involved in clinical decision making?	68%	30%	1.8%	0.2%	-
To try out new work roles or areas of practice?	44%	44%	10%	1%	1%

How important is it for a career structure to reward?	Very Important	Important	Not very Important	Not important at all
Clinical decision making	67%	31%	1.5%	0.5%
Manual work	33%	50%	15%	2%
Technical work	33%	50%	15%	2%
Interpersonal work	67%	30%	2%	1%
Functional work	47%	46%	7%	-



What do you think are the best features of the CURRENT career structure?

CURRENT RESPONSES – 14 August – 8 December 2006 (See below for previous responses)

- Provided a career pathway although not a flexible one.
- Recognising qualifications.
- I really do not have a view on this. As time has gone by the current structure has changed to what was originally promoted back in 1986. Divisional areas in Hospitals have not helped as we now have developed silos where everyone is interested in their own area rather than working together for the good of all.
- Not too much at all. It is an antiquated system and needs reforming. Poor recognition of skills. Payment reward for years of experience, rather than for level of responsibility. Many RN's, not too long qualified are responsible for management of entire hospitals, on a Yr 1 Pay rate.
- The level 2 position, providing some incentive for clinicians to maintain clinical practice.
- The fact you get paid for extra certificates, the ability to act up and across.
- Clear structure, allows alternative for managerial or clinical.
- Not happy with it.
- Upgrading the level 2 structure to incorporate more nurses.
- Increased opportunities for promotion and valuing clinical skills. Recognition of specific specialist skills. Clear guidelines to work to. Clinical skills acknowledged as equal to management skills.
- I think there are no features at current of the current career structure which is best. I agree there have to be changes.
- It was an attempt to provide developing roles. Under health systems changes the role depth I used to practice in has been reduced. The role has become much more generic not recognising specific knowledge, practice and skills.
- Having CNs available on ward for consultation in care provision and patient status.
- I think it will assist in recruitment and career development in the rural and remote regions staff are being recognised for the extra work they do above their "normal" duties.
- It attempts to address the level of experience or acknowledge the level of experience of nurses although not well.
- THERE ARE NONE.
- Rewards those who are prepared to obtain further skills and maintain up to date research and knowledge.
- Have never liked it. I think that it demoted Level One nurses and stopped them from being treated as professionals. I would rather see a structure for nursing that provided a more level playing field and enable the rank and file to have more access to information, and to be more involved in decision making.

Responses from 20 July to 14 August 2006

- It enables a career pathway. It provides a "supported launching pad" for succession with the level 2 role. This role is supported by the level 3 position, rather than being less supported in the initial experience in this role. It is better than what was in place before the career structure, in that it has given recognition to clinical nurses and clarified the 3 main competency themes within the traditional charge nurse role.
- None really. Unless you are above a level 1, you only progress in years of experience. and with the shortage of nurses years of experience don't count for anything, as you have young newly registered nurses running units on late and night shifts.
- Reliable advancement in wages, especially given that there is little or no opportunity for nurses to advance beyond a basic R1 level.
- The 1986 Career Structure failed in my opinion as it has not succeeded in keeping competent nurses at the "coal face" with the clients - Nurses leave the setting in droves. It has increased accountability some what from the pre 1980's nursing concept.
- Identifies SOME differences between skill/knowledge levels of individuals.
- Experience was taken into account as much as qualifications.
- Getting a pay rise each year.
- Nurse specialist role as an alternative to the clinical nurse position. This position provides recognition to nurses who work at the level of a CN.
- I don't understand the current career structure as it will not accept previous life experiences or qualifications to enable learning and practice in the community.



- Automatic Recognition for extra qualification - mid - (as opposed to applying for it and onus on midwife to prove she uses it).
- Some recognition for nurses who have completed further professional development, the best feature of this is that it is regardless of the level they are at ie. still eligible whether level 1,2 or above RN.
- I have only been nursing for a couple of months so I am unsure.

Responses from 18 May 2006 to 20 July 2006

- It enables a career pathway. It provides a "supported launching pad" for succession with the level 2 role. This role is supported by the level 3 position, rather than being less supported in the initial experience in this role. It is better than what was in place before the career structure, in that it has given recognition to clinical nurses and clarified the 3 main competency themes within the traditional charge nurse role.
- None really, unless you are above Level 1. You only progress in years of experience. and with the shortage of nurses years of experience don't count for anything, as you have young newly registered nurses running units on late and night shifts.
- Reliable advancement in wages, especially given that there is little or no opportunity for nurses to advance beyond a basic R1 level.
- Gives the CNC time to manage and run the unit instead of doing rosters.
- I don't think the current career structure is very good except for the new NP role. We need improved succession planning.
- Clear structure between management and clinical.
- The best thing is that there is a structure in place! it may not be perfect but at least it is a guide. Those who say there is nothing good about the current structure...maybe you're not working hard enough?
- Formal structure, with clear roles that are well defined.
- Easy to follow and understand where you fall into the current career structure.
- Nurses can move through management or clinical pathway.
- In most cases, the career structure provides for clear lines of accountability although individuals may be caught between different lines for program and professional accountability.
- That there is a career structure in place. This provides a basis for a more effective and rewarding career structure to be implemented in the future.
- Allows clinical work within level 2 & 3 roles, thus allowing monetary reward at these levels.
- Very good when first introduced - gave an opportunity to move into different areas.
- Being able to go to the Nurse Manager when you don't get on with the CNC, she is very supportive and impartial. The CNC can concentrate on the clinical areas and the Nurse Manager does all the HR work, rosters, leave etc
- Clear career path for administrative focus.

Responses from 5 April to 18 May 2006

- Easy to follow and understand where you fall into the current career structure.
- I think that the current career structure is excellent for rewarding nurses who choose to go down the management / administrative pathway, but has neglected the clinicians.
- Clear line of management.
- Allowed for different streams ie clinical and management.
- Worthless in small country hospitals, caused more problems than it solved.
- The ability to become a level 2 and remain at the bedside but be rewarded for advanced knowledge
- I think the career structure was appropriate for it's time but it has not kept up with the changing environment of the health system. Nursing needs to be rewarded and valued more and this should be reflected in the career structure.
- Can't really think of any.
- Opportunities for advancement.
- Diverse roles for nurses.
- Clinical role is separate from Management, allowing the clinician time to do clinical work.
- Difficult to think of any!
- It supports all nurses in their work. The 1 nurse to 4 patients is excellent, in my view this assists to deliver better patient care with better clinical outcomes. It gives all staff who apply for positions an equal chance of succeeding.
- There is some room to move but not a lot for diversity.
- Nothing. I think its important to financially reward staff who choose to stay at the patient bedside rather than seeking promotion, but I think this should be dependant upon skills rather than years service, otherwise you could simply qualify and do nothing for 40 years.
- Provides more scope than before it was introduced in 1985.
- Qualification allowances.



- There are no redeeming features of the current career structure.
- This has been the only system I have worked under.
- Support for less experienced staff. Recognition of knowledge and experience. Allows promotion for clinical work without management responsibilities.
- Identified roles and expectation of roles involved.
- Staff understand the roles.
- Encouraging continuing/further education.
- Currently there is some allowance for various roles.
- It's better than what was in place prior to implementation! It assisted nursing to gain professional recognition amongst other health professionals. It needs to be flexible enough to reflect contemporary nursing practice, now & in the future.
- Although limited it gives people a bit of an incentive to gain other positions if they wish.
- Nurses can work in a huge variety of settings, can transfer their skills across a range of settings, can use nursing to make a difference in diverse ways. e.g. having an impact on budget planning rather than passively accepting a budget.
- Ability to apply nursing knowledge in a lot of different areas.
- Some recognition of the role of the nurse educator.
- Support for level ones and twos by level 3 and above who provide coordination of education and clinical support.
- Support for each level of midwife through the structure of level 1, 2, 3 etc.
- Clear statements.
- Not sure but feel there is a vast area from senior RN1 with considerable responsibility to CN/CNC roles.
- Provide greater rewards for nurses with further education and who have a more senior role while still maintaining their level 1 status.
- Nothing, it is too hierarchical, too much management component especially in Level 3 & 4. What a waste of clinical competencies and expertise, and experience to sit the office doing management stuff.

Responses from 8 March to 5 April 2006

- Recognises clinical knowledge and skills, not just years of experience.
- Can't really think of any!
- The attempt to provide a structure that recognizes clinical expertise and experience.
- Recognition of qualifications – fiscal. The Nurse Specialist Role was excellent – shouldn't have been disbanded.
- Incremental pay increases in recognition of years of service and skills acquisition as a level one RN in particular.
- A small step in the right direction. Current career structure was determined by political/financial agendas.
- The diversity of roles that people can pursue from ie; the many different clinical streams, the involvement of nurse practitioner roles - rewards clinical expertise. The different professional streams such as management and education and research. The fact that nursing leaders (L5 and L4) have an operational focus and have the authority to influence not just nursing care delivery but how we operationally provide health care to achieve the best outcomes for the people we care for. The recognition we are now giving enrolled nurses with their revised career structure.
- Working in the eastern states I find the career pathway very limiting in comparison. So I find it hard to find the best features in the SA career structure.
- Has (at the time) provided a pathway relative to career development for (registered) nurses.
- Accountability within each role. Opportunity (although somewhat lessened now) for career advancement.
- Remuneration for Level 1 RNs/ENs who have completed further post grad studies.
- The structure is clear.
- Not many things.
- Can't think of any. As an experienced level one midwife in an acute area, I can't see any good features.
- None for the Level 1s.
- None for the Level 1 midwives.
- Nothing, all career structure positions should have a 5 years contract rather than until you retire. If you going to make Level 2 positions not permanent, then you should do it at all levels, it is so unfair and discriminatory.
- It gives many an opportunity to take on a greater level of responsibility that they would not otherwise.
- Have too many chiefs and not enough Indians.
- Having the support of a line manager ie Nursing Director - reduces some of the difficulties around isolation of practice in a large organisation. Then again, the current structure also allows for a certain amount of autonomy in the workplace.
- Greater recognition of ability and educational levels achieved with a wide range of options for nurses to choose from.
- Initially clarity of levels / roles. However, that has long since been eroded, undermined to a very confusing mish mash that no longer recognises work performed or responsibility.



- Some recognition of the diversity of roles in nursing. The fact that there was a formal process and recognition for a "clinical nurse consultant".
- Unfortunately, the questionnaire puts nursing and midwifery together. There are very different issues for these different professions. It would be beneficial to have a questionnaire for midwifery that midwives respond to rather than trying to address the same issues in one questionnaire that nurses and midwives respond to without clearly knowing if they are nurses or midwives responding.
- None, we have a multi-layered structure that overlaps, that fails to clearly define roles, that set out to do A has ended with B and nothing has been done about it for years except to put out fires. Sorry, but don't have a good thing to say about it.
- I don't think the career structure in its current form has been working for many years and can easily be suited to what organizations perceive they need.
- That it rewards people who choose to remain in the clinical area.
- Not much! Very difficult to advance unless you can work full time.

Responses from 17 February 2006 to 8 March 2006

- Multiple roles (diversity) within each level of pay/responsibility.
- That a career structure review is being undertaken and that supporting evidence for the need is presented.
- The roles of each classification are defined, so most people know what the expectation of each position.
- That there are different levels although this is limited.
- That the need for this review is well identified.
- That there is one even though it does need to evolve.
- Ability to further career in metropolitan centres fairly accessible. Not so easy in regional centres (less positions available to aspire to, more permanent workers. less mobility between positions).
- Well known structure, consumers and public are aware of the structure.
- It allows for advancement (to a point) while still allowing people to stay at the clinical level.
- Recognition is given for clinical/management expertise.
- The current clinical role - specialities etc - although it does not go far enough it is better than it used to be.
- Structured from Level 1-5.
- Clear career progression.
- Promotional positions in the clinical area eg RN2.
- Introduction of Nurse Practitioners, but that has taken so much time to implement, and in SA just beginning and is exciting.
- It enabled the clear delineation of nurses work in the 1980's and reflected the curriculum being taught in higher education post-graduate programs but it is now outdated.
- It was an attempt to change the then status quo, however in today's situation it is no longer as fair/appropriate.
- Having Clinical Nurses that are able to support the level 3 role and have a stepping stone to learn the role of a Level 3.
- 1) The GNP immediately after the 3 year Uni degree. 2) Can go to Year 10 as RN-Level1.3) Can 'fill' in for jobs above current status.
- As it was intended to provide pathways in clinical, management and education - though am not sure that this is how it is currently.
- There are limited advantages to the current career structure. It is restrictive, does not focus on professional development or reward professional growth. It also does not cater for the expansive role of the nurse/midwife in this current climate.
- Loyalty and commitment rewarded, versatile paths.
- Recognition of post graduate education.
- It has gone some way towards recognising and supporting professional practice, career pathways - however, it is now dated.
- I think the CNC role (where they are properly supported by nurse managers and where they get their IP days okay) is providing a great opportunity for nurses to lead, both clinically and developmentally.
- I think the clinical career pathways for clinical are OK although promotional opportunities are limited. It is also frustrating that those who perform well are paid the same as those who perform poorly or at a basic standard.

Responses up to 16 February 2006

- It was intended to reward those who chose to stay clinical & those who chose a management path. It does not do this now. We have too many clinicians working in other than what their role is intended. There are many nurses & midwives in other roles, ie IT etc. They attend meetings all day and do not provide clinical leadership in their units. The CN role has become the pseudo manager and does not provide clinical leadership. The Unit Heads in many areas do not have any hands on contact with patients and do not have the confidence of their staff when they have their clinical judgement questioned.



- Giving a focus for management giving a focus for education giving a focus for the clinical experts.
- Reduced levels of management. Chance of advancement from RN to clinical nurse not there before. Makes nursing more professional.
- Not many good features. There is no flexibility and little opportunity. There is little leadership just top down management. No development of new roles no nurse practitioner. Nurses don't need to stick to nursing, they can cross over roles. There needs to be a cultural change within nursing.
- There has been some success in reducing the top heaviness of the structure. Unfortunately this has also meant that more of the administrative work has been 'pushed down' to the clinical levels.
- The fact that there is the different levels of classification and acknowledgement of different roles that it exists and can give rewards for increased skill and knowledge base.
- Staff patient ratios.
- It provides opportunities for nurses to specialise in a variety of areas.
- Clear levels Progress to next level.
- None, as midwives are treated as nurses not as separate practitioners in their own right.
- Reward for experience, expertise, education.
- A progressive structure and career path.
- The diversification of midwifery practice from the mainstream nursing pathways - this creates a different focus and mindset with regards to how pregnancy and birth are "managed" (ie: the focus has evolved into a concept of health promotion and normalisation of birth).
- Reward for time spent in nursing however a level 1 9 is not always ready to take on a CN role just because of time spent in a job.
- Opportunity for nurses at Level 2 to experience both clinical and management roles so they can decide what direction they might like to take in the future.
- Introduction of levels such as nurse practitioner.
- Fairly defined roles, well established. How broken is it?
- Not a lot - little recognition of individual skills if affected by the place or if staff are able to work.
- One of the aims was to increase promotional pathways for nurses who wish to maintain their clinical practice but not become managers. I think this has happened at a tertiary level of care but not with Primary health care practice.
- I'm having trouble with this one! I guess the introduction of Nurse Practitioners and Nursing Specialist was a good idea.
- Paid for the years of experience; Nurse Practitioner role; Time out for management issue for a unit.
- Annual Leave Sick Leave Maternity Leave The fairness in appointing staff to new roles. That all new positions must be advertised. That you can negotiate your contract – confidential.
- A structure which assists advancement and recognises commitment to achievements, ie the levels 1 & 2 within each level.
- You can focus only on your divisions activity if you wish and have no shared view of organisational issues
- Originally provided opportunity for advancement within nursing career.
- Introduction of nurse specialist. These nurses have avenues to achieve higher in their RN role and assist in education of both clients and peers. Unfortunately they are unable to get supernumerary days to assist them so all work is done in their own time.
- CN positions giving respect to knowledge and skills but numbers are too limited.
- Flexibility of nursing careers available. Initiatives to encourage ex-nurses back into the workforce - training plus working hours to suit the person.
- None, all the senior nursing roles still take the most experienced nurses away from the bedside.

What do you think we should focus on in redeveloping our professional career structure?

CURRENT RESPONSES - 14 August 2006 to 8 December 2006 (See below for previous responses.)

- Giving nurses the opportunities to work in different areas, different roles. Ensuring that nurses can feel that they are making a valuable contribution no matter what level they are.
- That the structure allows for all nurses to have promotional opportunities, not as limited as it is at present. That clinical promotion has more opportunity than level 3.
- Previous experience, educational status.
- My belief is that we need to get back to clinical roles rather than have the increase in roles taking a "management" function. There is a difficulty getting staff when it is needed but there may be a number of staff working on management rather than clinical roles. I would hope that nurses & midwives could practise appropriately after hours rather than having to pick the roles of others such as clerical & admin roles.



- Recognition for qualifications and tertiary degrees. To recognise that nursing and midwifery are professions in their own right and that we are trained with the knowledge to make clinical decisions autonomously. Yet nursing generally is resistive to change. It is often just as difficult to get older, hospital-based trained nurses to accept a more responsible role for contemporary RNs & RMs as it is for doctors! They are familiar with the nursing role of yester-year. Until we raise the profile, people will choose to enter other professions over nursing as they will be better paid and receive respect & recognition as a knowledgeable, well-educated professional. The old structure did not allow for professional recognition or advancement. We have had the same CM and CN in this hospital for over 20 years and the positions have not been available for anyone else to apply.
- Rewarding advanced practitioners beyond level 2 & 3 (even without Masters qualifications).
- Recognition of prior learning, current education and not dropping down in pay.
- Academic development/reward. Support for external courses. Support for clinical supervision - should be mandatory!!!
- Recognition for advanced clinical skills.
- In our hospital an educator for the many students and to give assistance to staff in their own professional development. 5weeks annual leave for country OR staff who have to be on call for up to two weeks each month.
- Improving education options.
- Recognising those level one RN's that do more than level one RN work. Recognise the role of the DON, and not dilute the importance of this.
- Nursing needs to become more flexible to meet the needs of Gen x and Millennials. I'm a 1976er and to try and hold down a job, plan a family and perform effectively at work is a challenge. I'm a good nurse, intelligent and hardworking but I am having a hard time working out how I'll be able to juggle this with motherhood. Mortgages don't get paid by one income these days...for the nursing profession to retain and recruit the "right" nurses there needs to be more flexibility in hours. Baby Boomers just say "do nights, that's what we had to do!" that attitude isn't helpful and for most nurses impractical and undesirable.
- Opportunities for community health workers to have their skills acknowledged to enable promotion to occur outside of the management role. Value and promote the Primary Health Care role.
The focus should be looking at getting people to understand that nursing involves patients and working together. There are too many bosses and not that many workers.
- Reclaiming specific nursing practice areas and providing more options for specialising in clinical practice. I have now worked as RN 2 for the majority of career, to gain a promotion to RN 3 would mean a move away from clinical work. I want to progress to a clinical specialist not a manager.
- More flexibility within roles. Recognition of autonomy. Equal weighting to positions site wide both in community and acute sector.
- Developing the up & coming junior nurses as part of succession planning.
- Broader streams of expertise.
- Developing a system that enables/promotes nurses working in variety of settings to keep broad skill and knowledge base well developed.
- I think country DONs and CM need support. They are often working in isolated roles with little or no support and they often have to take on a clinical role and attend to the management issues after hours etc. I also think the introduction of PDOs for level 3&5 in the country (which would be cost neutral) would reduce burn out as the reality is TIL does not get taken.
- Better pay.
- More acknowledgement of experience as well as qualifications, not focus just on the qualifications only. Acknowledge the diversity within nursing roles. We don't all fit into boxes eg the banding within level 3 currently doesn't reflect the roles within the community which then makes it hard to show what level you work at, which impacts on reclassification etc. I think it should also reflect responsibility and expertise instead of just how many beds or staff you have responsibility for.
- Salary, mentoring of new staff, bullying and harassment issues. Moving away from EN (with a Cert IV) - they should be reclassified as Nursing Assistants, or Practical Nurses. EN's with the Diploma should be Registered Nurses, and people with a Bachelor Nursing should be Registered Clinical Nurses.
- How to move into other areas within the nursing profession.
- Acknowledge all roles in old structure. Do not leave current Level 2's with no option or being swallowed up by this new structure.
- The role of clinical nursing, and documentation, rather than huge amounts of time spent in what is essentially an administrative function. I resent having to spend hours at computers, filling in forms, photocopying which could be done more efficiently, effectively and economically by additional admin assistance (I don't have any). The time



spent here would be best spent with clients, education, professional development. It has been argued by some lucky clinicians that do have support, that it takes their time telling others what they want done, I would willingly spend a few hours working with someone, which would seriously provide me with approx 1 day a week for clinical involvement.

- Using the nurses you have now, develop extensions of their roles and nurture what you've got, they are getting older.
- Nurturing and fostering novice practitioners to become involved in professional development. Need to encourage, support and listen to what is being said. Management spends a lot of time attending meetings etc without real change occurring. Need to improve work environment on the floor.
- I think you must be careful of linking advancement to the obtaining of Grad Dips etc. Not all nurses are able to do these for various reasons. Thus very experienced, knowledgeable nurses are paid less than junior nurses that have a Grad Dip, but still need to be chaperoned. In my case this meant that I turned my back on an area in which I had 20 years experience, and had had a vast amount of tax payers money invested in me, to work in an area in which I am a novice, because I felt so exploited. People learn a lot on the job. This needs due recognition too. My frustration with this issue has been the final straw that has lead to me now working towards leaving nursing. I can not see that I will ever be recognised for what I bring to nursing, given that I will not be doing a Grad Dip, and I will not be put in the position where I get asked to baby sit nurses earning more than me because they have a Grad Dip, but lack the experience to be able to understand what they have learnt means in clinical practice.

Responses from 20 July to 14 August 2006

- A better way of progression to levels higher than level 1.
- Valuing all roles. Identifying what is core nursing business. Identifying what is extraneous to this. Working out how best we can ensure that we are focussing on the core business of nursing.
- Improving and updating skills incentives to upgrade skills.
- Ensuring that nurses receive fair and adequate recompense for the work involved, including the impact of shift work, the variety of roles, tasks and knowledge required.
- Career structure is too top heavy.
- Improved work conditions, shift times, remuneration increases to acknowledge true role of nurses, particularly in smaller hospitals where their roles are very diverse.
- Retention and recognition.
- Acknowledgement of - varying degrees of ability - autonomy of roles - specialised skills/knowledge Regardless of mode of learning.
- Put training back into the hospitals.
- Reward / encouragement for those nurses who not only fulfil their role competently but take on other diverse roles in their unit.
- More incentives to stay in the profession, as we are aging. Shift work is getting more difficult, especially night shift.
- More levels for regional areas. Many nurses that move up the career structure in rural area have usually been nursing there for a long time. New nurses that work in the rural areas usually move on due to the lack of career opportunities to better themselves. In our hospital, each ward has one CN, I have been nursing for 10years, and the same CN is in this role. I have undergone further study, but it doesn't look like in the future this person is going to leave. Where do I have to go to further my career when my entire family lives in our town?
- Advanced practice roles, Clinical Nurse specialist roles for nurse who practice at an advanced level, and provide leadership, but are unable to obtain Level 2 position due to lack of opportunity, lack of positions.
- Opportunities to improve our clinical skills by performing them in the environment where we wish to work.
- Recognition of experience, intuition, ability to relate to people, empathy, common sense.
- Increase capacity for recognition and reward(not necessarily financial) for nurses who are developing their skills and knowledge base and providing quality patient care. Level two RN's did not get much out of the last EB agreement, more financially rewarding being level 1 yr 9 RN with in-charge allowance.

Responses from 18 May to 20 July 2006

- Improved business and leadership skills.
- Valuing all roles. Identifying what is core nursing business. Identifying what is extraneous to this. Working out how best we can ensure that we are focussing on the core business of nursing.
- A better way of progression to levels higher than level 1.
- Improving and updating skills; incentives to upgrade skills.
- Ensuring that nurses receive fair and adequate recompense for the work involved, including the impact of shift work, the variety of roles, tasks and knowledge required.



- Career structure is too top heavy.
- Improved work conditions, shift times, remuneration increases, to acknowledge true role of nurses, particularly in smaller hospitals where their roles are very diverse.
- Not to lose the good points of the current structure.
- Supporting the nurse on the floor, providing satisfying promotional opportunities, recognising people's knowledge and skill.
- If we are to become more professional, education should be at the forefront of the career structure. Years of practice means nothing if your mind has been closed to current best practice/new skills!
- Professional structure which devolves and recognises the need to manage clinical, Safety/Quality, Human Resource and fiscal policies, which ultimately effects how nursing care is delivered.
- We should focus on the ability for the nurse/midwife to progress through the career structure in either management or clinical roles with the same opportunities and remuneration available in both streams. ie NP's
- Pay points - I believe that there should be a greater increase in salary each year at the lower year levels to encourage retention of junior nurses. Should also look primarily at the tasks/responsibilities that nurses have and allow greater scope of practice at all levels.
- Leadership and cultural change support and innovation.
- Defining out what is involved in being in a specific position. Broad enough to cover all aspects of nursing, but concise, so no chance of being put in the wrong category, and getting less than entitled to.
- Many things! Most important is maintaining numbers of effective and efficient nurses. Some aspects include valuing the diversity of nursing roles from the technical expert to the communicator and not necessarily placing one above the other. Provide incentives and acknowledge those who support and encourage young people to take up, stay in and grow in the nursing field.
- Acknowledging the expertise that nurses have. Credentialing as a way of maintaining appropriate rewards for continued education.
- Many nurses are looking for challenges in their career and the current structure in place does not provide the challenge for some of the highly experienced clinical nurses (although nurse practitioners have been an improvement). Preceptoring and teaching students within my clinical area is included in my position as a level 1 and is expected to be part of my role but no provision in regards to the extra involvement and support is acknowledged. i.e. career structure!!!!!!!
- Recruitment and retention strategies eg. Mandatory conference attendance for senior nurses supported financially by management.
- Maintaining / Regaining level 3 input into clinical practice.
- More clinical learning in a hospital setting. Recognize the existing skills of those of us who joined nursing as a vocation, and accept that our path is different then those just commencing their career, and our goals also. We are the clinical teachers of the future and are tired of feeling unworthy because we do not see that the developing career structure was or is for the better.
- Supporting RN's to work the hours they want without decreasing their options of advancement. Encourage maintaining knowledge and skills for patient/client care.
- Need to have greater reward for clinical nursing excellence. Need to have senior clinical staff given more roles in supporting/educating junior staff.
- It is currently a disadvantage in dollar terms to work Monday to Friday as level 3.
- Getting CNC's back into clinical for teaching as they are meant to be the experts.
- Alternate pathway for clinically focused to same level as admin or research focus.
- Clear expectations of what is required to fulfil position

Responses from 5 April to 18 May 2006

- We should focus on the ability for the nurse/midwife to progress through the career structure in either management or clinical roles with the same opportunities and remuneration available in both streams. ie NP's pay points. - I believe that there should be a greater increase in salary each year at the lower year levels to encourage retention of junior nurses. Should also look primarily at the tasks/responsibilities that nurses have and allow greater scope of practice at all levels.
- Leadership and cultural change, support and innovation.
- Defining out what is involved in being in a specific position. Broad enough to cover all aspects of nursing, but concise, so no chance of being put in the wrong category, and getting less than entitled to.
- Appropriate financial reward for management/clinical roles that have 24/7 accountability. My clinical nurse does not want to relieve my position because she earns more than me with penalty rates! Needs clearer delineation between skill levels/ pay scales.
- The opportunity for nurses to advance through a career path with a clinical focus.
- Provide equity across levels, recognise differences.



- Try and have a balance of diversity of different roles working along with those who choose bedside care. Need to take care not to be too narrow in the focus of the roles - who does what is left? Need to ensure that there is balanced financial remuneration for those who work in level 3 positions and make them attractive so that there are relievers available.
- Equality, pathways other than management.
- That clinical people who have already won a promotional position eg level 2s are not devalued or disadvantaged. In addition please be aware there are plenty of level 2s out there who are working autonomously, with great responsibility and knowledge, but because they (we) work Monday-Friday are not being remunerated anywhere near the level 3s or 1s who are on shift work.
- Autonomy for skilled professionals, recognition of skills, education for students and new staff.
- Creating new, multiple opportunities for professional development with more adequate financial remuneration for up skilling to provide challenging and financially rewarding avenues for experienced nurses to aspire to.
- Look at the increased demands on nursing to make decisions related to health care. Look at workload related to position and not just the position. Promotion should be based on performance and not a fixed number at each level. No equity in current career structure. Need streams for management, education and clinical and the structure must be clearly defined.
- A more diverse structure that allows for portability and movement through nursing.
- Interpersonal communication between staff and between nurse and patient/client. Recognition of professional development and life skills. Recognition and acknowledgement that there is more to nursing than management of equipment and acute care health promotion and primary health care.
- Focussing on clinical expertise at the bed-side. As nurses gain more knowledge they tend to take on specialist roles 9-5 pm and tend not to be at the bedside so much.
- The expertise of clinicians remains at the bed side, but that there is sufficient succession planning for all roles.
- The current clinical and management melded role as we have in the country is just too hard - it was developed prior to EQUIP , risk management, AIMS etc that now takes up so much of everyone's time - it is patient care standards work that always drops down to the bottom of the to-do list. I honestly believe that we need CNC's back on the wards - a delineation of the Clinical and Management roles is becoming essential. Hmm - I believe we tried this once back in the late 80's - it appeared to work until someone cottoned on to how expensive it was to maintain good standards of clinical care.
- I believe there needs to be more support for the CNM role. Currently there is so much which is non-clinical piled onto us that it makes us wonder whether we are clinical or administrators. There needs to be work redesign so that CNM role can be clinical not so much administrative burden.
- I'd like to see the level 3 and level 2 needs of country considered. These positions have a lot of back up in the city, here they do not. A lot of us are doing DON work as the expectations on the DON are excessive and they are away from the units a lot. We still have to do the same things metro hospitals do but with a lot less.
- Rewarding innovation, skills, and attitudes by providing promotional opportunities. Proper definition of roles, responsibilities and expectations. Financial reward for Level 2 and 3, making pay differences larger. As a L3 I get less than my L1 partner.
- Allowing more opportunities to advance without having to following a management path. Introduction of a variety of paths that allow for advancement.
- Should focus on a wider diversity across levels. There still appears to be a leaning towards level three being of a more managerial type role, and even if clinical seems to have a managerial component in it. Mental health nursing needs to be seen as specialised with significant proportion of work and training in the role at the client level undertaking placements to gain experience. It seems as though mental health clinicians can undertake training at Uni with little contact with patients when this is an area in which ongoing clinical contact is essential and the only way to learn. Specialised fields should have to have additional training before they can be admitted to a role.
- Ensuring nurses continue to manage, lead and control nursing. Whether it be at a clinical, educational and management level. Nurse managers need the professional and educational support to undertake this. Clinicians need appropriate management support to undertake their role as clinicians, auditors and patient/staff educators.
- Encourage individual decision making within a broader framework to allow for the expertise of the individual at all levels to be encouraged, rewarded and shared.
- Separate the management and clinical responsibilities as originally intended.
- Succession planning of Registered Nurse Roles.
- Developing experienced clinical roles that help to inform and develop broad practice.
- Recognition for continuing professional development initiative. Rationalising some overlapping roles (e.g. CNC/NM).
- Providing a better system for integrating the GNP programs to improve the retention rate and help them integrate better into the workforce.
- More development of the nurse practitioner role and extended practice nursing roles.



- Ability to move between different areas in nursing ie career paths.
- Flexibility for modern nursing practice, as well as predict professional nursing roles for future healthcare needs of the population.
- Developing a friendly happy supportive working environment so that people want to stay in nursing. A Clinical stream so that those that want to do budgets and management can and those that want to remain in the clinical stream can be rewarded.
- Currently there is a limit for advancement. The CN role (or equivalent) should be available to any staff member that shows the initiative, knowledge and expertise in an area. However, the original CNC role has gone. It has lost the clinical expertise role and become one of management with little patient contact. More and more is sent down to these people taking them away from their intended role. Any removal of level 3 management or level 4 would reduce cohesiveness in like areas and totally remove the ward based level 3 role away from the people that matter the patients. However the level 5 role in many ways is obsolete - with a motivated interested level 4 this is not required.
- Ensuring quality education is provided within all settings, including ward areas. Not as an outside service but included in each unit's staffing quota.
- Ensuring life-long learning opportunities for nurses and midwives, especially preserving the availability of professional development/education programs within the workplace to ensure accessibility for a wide range of nurses/midwives.
- Offering diversity for those in nursing so we can retain their knowledge, drive and caring within nursing, supporting and actively promoting nursing as a career with places to go and things to do.
- Yes to create flexibility of role progression, transfer within roles and accountability of a role, more days set aside for in-service.
- Continuity of midwifery care so that all midwives provide care for women throughout the continuum of their pregnancy, labour birth and postnatal period.
- Midwives providing the continuum of care for women through antenatal, labour and birth and postnatal care.
- Increase value placed upon the clinician, clinical decision making, and their accountability. Take into account rural settings as opposed to metropolitan. Country hospitals need a recognised expert clinician as much as a NUM. Ensure pathway for expert clinician other than via management. Clinicians should manage clinical areas/clinicians but not necessarily have to manage industrial / organisational tasks. Ensure nurse managers and expert clinicians hold the same degree of autonomy, accountability and are valued equally - both financially and in ability to bring about change. Clinicians should be making clinical decisions and managing clinicians on the floor not managers who may have nil or little current clinical ability. Both absolutely necessary. Raise profile of mentor who actively supports students, graduates, novice and experienced nurses and supports profession.
- Defining nursing roles within the health care team and providing flexibility for moving between roles.
- Support for continuing education.
- Rewarding nurses who are prepared to spend time evaluating clinical practice whilst still having a patient workload Recognition of the smaller specialty streams that are emerging and have very little support from nursing organisations by developing links with professional medical bodies who may offer a 'token' association.
- It's worth looking into as long as it is beneficial to the nurses and the care that they provide.
- To date the highest paid nursing positions rest in management. With the role of Nurse Practitioner there should be greater incentive via reimbursement to nurses choosing this pathway. The clinical role is not as valued in today's health care centres and it is time to truly put the work that clinicians do in the limelight.
- To be more clinical in Level 3 and 4, and to undertake research which is absolutely lacking in nursing. These people in these positions are capable of doing research but they focus too much in management, pass some of the management to their CN or senior staff. Nursing is about delivering the best patient care.
- More support in getting parents back into the workplace. We need to look after these people and encourage them back. Look at having childcare fees paid by the hospital. With this as an option I assure that more parents will do extra shifts!
- More leadership skills

Responses from 8 March to 5 April 2006

- Look more at abilities rather than pieces of paper. Nursing is becoming overly involved in qualifications and not in the physical activity of nursing.
- The Nurse Practitioner role is poorly addressed in the current structure. The banding has been unsuccessful and open to interpretation by employers. For that matter the banding for level 3 positions has not been effective.
- Accountability in maintaining standards once a promotional role has been achieved i.e. if you are a unit manager or specialist or consultant, what are you doing to make sure you are efficient and up to date within that field of expertise? Who are you accountable to? What about 360 degree performance reviews? Why are nurses so scared of sharing knowledge and receiving performance reviews? We also need more roles within the education



banner in the workplace not just the universities. In the business world you are paid according to your level of responsibility and your performance!!!

- More definition of roles. Rewarding skills, knowledge and experience on an individual level. Increased capacity for promotion-not having to wait until someone retires.
- Opportunities for development and autonomy without having to become management. Clinical experts need recognition in management and academia they should have opportunities to share their expertise within their professional role.
- Better conditions and fiscal reward for Level 3 and above.... 6 weeks Annual Leave, Better base rate salary to make it more attractive for others to act up into a level 3 role without losing their level 1 & 2 benefits, particularly shift loading and annual leave accrual.
- Nursing levels 2 & 3 (middle management) should be contract positions so as to promote best practise in terms of client centredness/outcomes and the promotion of positive ward politico-cultural dynamics. This way, patients get better care & issues of bullying and harassment of staff are better addressed. Reappointment contingent to anonymous 360 reviews and consumer feedback. Ultimately it may contribute to the retention and recruitment of nursing numbers as the profile of nursing both from within and out changes in alignment with a greater sense of professional satisfaction. ADDRESS THE CULTURE before looking at the career structure.
- One of the major aspects of the career structure should recognise the nurses who have multiple qualifications but who are paid at the same scale as newer graduates, ie experience is not recognised.
- Greater work movement and flexibility between positions.
- The ward CNC/ CNM role is extremely difficult and many feel frustrated and torn between 'management' responsibilities and spending time with their patients. I would like to see greater support for this role. We require nurses at senior levels in organisations (ie: L4 and L5), to promote nursing and ensure that organisational decisions remain patient centred. The nature of these roles means that they are sometimes distanced from the ward areas - I would suggest one clinical shift per fortnight for L4's and L5's. Redefining how we might provide care so that nurses can focus on patients rather than becoming bogged down with a whole lot of other stuff that could be delivered by a third level worker.
- Develop more pathways for career development. Flexibility part time/ job share etc, to retain great RN's but still allowing further career development- recruitment! More access to senior experience and knowledge at the ward level, but also the senior staff being recognised for this knowledge.
- Clinical retention for senior nurses at the patient level by incentives & value to coal face. Equity for level 3 nurses ie. banding does not value the clinician. Designated nurses are rewarded over others with less client/patient groups.
- Recognition of skills and qualifications, opportunity for ongoing education and development.
- More post graduate educational support for novice RNs entering the workforce Non- Nursing duties eg clerical duties especially in rural areas. Improve and acknowledge post grad qualifications equally across all sectors of nursing in gaining further educational support eg. in the organisation I work in community nurses are given more support than Nurses in the acute care setting of the hospital.
- Making the roles within the structure clearer.
- Not have people become level 3 & 4. and stay in that job for life.
- Expert level 1 clinicians particularly in acute areas who often have to perform duties of medical staff eg suturing, resus. of mothers & babies, IV insertion. teaching of med. students & junior medical staff are not recognised or rewarded. CMCs role is now more a management role with little clinical input due to meetings, computer work.
- RM's in L&D should be rewarded for their expertise in handling the intricacies of a busy labour ward.
- Monetary compensation for the midwives undertaking the education of new midwives in labour ward, Education is expected and given but this extra important work is undervalued at the moment.
- Should focus the role of the CMC role, they are the clinical expert but they hardly spent any time or very little time in clinical areas. What a waste to be promoted and spent majority of their time in management, should allocate it to the CM.
- Recognising the vital role the experienced clinician has in the health profession, with improved financial increments. Changing "management" roles to administrative. So called clinical managers are not currently managing the clinical practice of staff, but have mostly administrative duties. All managing (education and supervision) of inexperienced staff is done by senior clinicians without remuneration.
- Getting people to actually work as a nurse rather than somebody only interested in paper work or working at computers.
- Not enough level 2's should be 1 per so many beds or departments.
- Why are we redeveloping our career structure?
- A greater patient/client focus with more clinical teaching for nursing students to make them more aware of the career that they have chosen. More recognition for those that have completed further study but are now only able to be recognised as a level one RN despite having more qualifications and the same or more clinical experience than those at level two or above.



- On the job support for nurses/midwives. Best working conditions and pay possible for nurses/midwives. Easily accessible ongoing learning for nurses/midwives.
- Pathways that allow nurses to traverse the system across settings and / or recognise nurses that do.
- More funding for hospitals/community health to recognise and use the expertise and diversity of their nurses. For example, you can be working as a Level One RN and have a lot of skills and experience but there is no opportunity to utilise these all of these skills. If more funding was available the hospital could recognise and reward the nurse for the extra duties/portfolios that they could undertake eg. education, research etc.
- "Our hierarchical structure." Too much emphasis ascribed to moving up a hierarchical structure that sees the systematic disempowerment of those at the bottom. Hierarchical structures do little to inspire creativity and free expression and in turn contribute to the dehumanisation, stifling and despair many at the coal face experience. There needs to be greater emphasis to ensure individuals with autocratic tendencies are identified and then effectively dealt with. To ignore the impact of such individuals is an abuse in itself.
- Create positions/methods at a middle management level, whereby experienced nurses are given the time to monitor patient care at the bedside, to observe, educate and support more junior staff.....and also given the authority to implement change.....ensuring excellent, not mediocre care. These nurses would need formal training in teaching, leadership and communication skills. Yes, we are all busy and a lot is expected of us, but all too often things "fall between the cracks" because of poor communication, lack of good bedside teaching or a less experienced nurse being unaware of all the facts.....i.e she "doesn't know what she doesn't know".
- One might argue that we already have clinical educators, but a good nurse does not necessarily make a good teacher. A culture needs to develop where good education is expected and information is willingly shared, both formally and informally. A clinical educator who spends a lot of time in her office, planning the next study day is not the answer.
- Address midwifery issues separately to nursing issues.
- The multi-faceted aspects that now form a part of the clinical nursing role, eg., care provision, education, mentoring, etc.
- A career structure that lasts for a career, ie entry to retirement. Less hierarchy, less bureaucracy and more related to skills, and not all clinical. Give clerical jobs to clerical, cleaning to cleaners, and patient care jobs to all sorts of nurses. FIX the pay differential. FIX the pay scale - if I am highly skilled, pay me for it, not because I worked 9 years. Have three layers - Baseline nurse, skilled nurse, highly skilled nurse, be they bedside, ICU techno, quality improvement or administrative nurses. Ensure older senior nurses don't have to demote because working fulltime is too hard. If you want good senior staff, they will NEED training. This takes time, and some of this time must be work time. Finally, rip the whole thing apart and build from scratch, no matter the cost of doing this. Really look at a simple structure, with multiple paths and cross overs, match with education, ways of measuring success and failure. Move from hierarchy and years of experience, to actual experience and skills.
- More recognition of those who may work in integrated roles.
- Allowing a structure that recognises that even people who can work only part time hours may be perfectly capable of undertaking promotional roles. Increase acceptance of job-sharing, flexitime and other novel ways of creating a truly equal footing for people to progress.

Responses from 17 February 2006 to 8 March 2006

- Nurse educators, rewarding progressive practice, clinical supervision is a must.
- Opportunities to progress to Level 4 or 5 very limited (unless you manage a hospital). These opportunities should also be open to clinical staff based on their expertise, qualifications and experience as well as other specialties including staff development, community health roles etc. Lack of opportunities in country- no RN4s, only EO/DONs of Hospitals. Does not take account that some RNs coordinating regional portfolios/working across multiple sites, but cannot progress beyond RN3 Level, as the banding heavily favours direct clinical roles and clinical supervision.
- Aged Care: changing demography indicates a huge increase in services. It is the 2nd largest area of employment for nurses and it is the equally oldest age group of nurses. With well documented evidence that nurses are leaving this sector in droves, we need to expand the career structure to include aged care nurse practitioners with on call allowances. The wage disparity must be addressed to retain those existing nurses in aged care. Career structure needs to support advanced practice nurses that extend practices beyond an RN but are more clinical than a CN.
- Allowing 'progress' whilst remaining in clinical practice.
- Professional Accountability - if you are being paid RN1/Level 9 that you take on roles within the organisation if you are employed above a level 1. That tertiary qualifications are mandatory - you cannot get into positions just because of the amount of time you have been in the organisation. Country career structure may look different to the metro regions. Nurses are expected to take responsibility for their own professional development without relying on organisation. Education positions support nurses and students in organisations. Flexibility - at present



you cannot jump from RN Level 1 Year 4 to 9 without waiting for the time to elapse. More emphasis on skills rather than time in an organisation.

- I think the CNS role like in the Eastern states is important I think that Paediatric nurses who work in Paediatric institutions should have a qualification and that they should be supported by their work place to undertake this.
- Need career structure for an advanced practice nurse ie: those RN's working towards NP role and are being mentored for that role by supportive health facility.
- Diversity, ability to develop and implement different types of roles. The relationships between roles especially at Level 3 and up.
- Focus on support for new graduates with increased clinical support for students also. Allocate positions for senior staff to assist transition. Definitely some sort of recognition that the necessity of non nursing work carried out by nurses is detrimental to patient care i.e. country areas- cleaning after hours, orderly duties, courier and ward clerk duties, security duties all performed by nursing staff impacts on time available for patient contact.
- Consistency and congruity in roles and responsibilities between sites, workplaces and wards of each level of worker.
- Further encouraging people to be involved at the clinical level while still rewarding excellence. Not appointing people to positions by "default" - e.g. length of time should not be more important than clinical skills and knowledge.
- The current career structure is good but with the additions of NP and extended nursing roles it requires modification.
- Recognising scope of practice ability for nurses/midwives to be considered experts in their role.
- Actually focussing on nursing.
- The patient to health care worker relationship- should become more outstanding and we should cater to the patients needs in the way they would like.
- Restructuring R.N.(Level 1) to year 12-15 with remuneration for same.
- Rewarding all areas that involve clear increase in span of control/care including management, education and more particularly clinical expertise.
- Acknowledging skills pertinent to specialist areas, such as critical care. Also recognising that these nurses are indirectly responsible for all patients in a hospital through attending met call and cardiac/ respiratory arrests.
- Ensuring roles where nurses work autonomously in a community setting within a multi-D team are considered eg; Diabetes Nurse Educators, Continence Advisors, Community Midwives and the focus is not metro-hospital-centric.
- Not losing any ground that we gained in remuneration. Focus on the future health reforms ie community/primary health focus. Reduce the number of managers and focus on autonomy of practice and professionalism of nursing. This implies that nurses do not need so much constant supervision from each other to ensure best practice.
- Ensuring those Level One RN's who do above their current roles are recognised through appropriate remuneration. Better recognition for DON's.
- A model which looks at a broader focus - community development which includes nurses not just RDNS, nurse practitioners, recognition of worth to the L1 position, the EN diploma - those who choose to continue with the clinical focus and not seek managerial positions, selection criteria that promotes nursing as a great career not a default choice.
- More equity in the positions that are currently being supported. As a NUH who has a wide range of nursing and multi disciplinary staff to manage I am dismayed at the lack of recognition that these leadership roles currently get. With the implementation of Nurse Practitioner for example they are part of the unit that I manage with the medical Unit Head however they are at the same level and possibly will be at a Band C level shortly. The NP have no budget to manage no people to manage and the ultimate responsibility for the unit is in my position however they get paid more than me and there is an unclear accountability. They have line management responsibility to me but that is all. The new structure needs to financially recognise these positions as the medical award does with an allowance to improve this imbalance at the very least.
- 1) Skills/Competency standards to go from years 1-10 with proviso to go to Yr 12- with remuneration- proved by Personal & Professional Development. Not just 'yearly' promotion. 2) More recognised 'speciality roles'.
- We need a new structure to better reflect the changing face of health care delivery, i.e. out of the hospital setting and to reflect community based roles.
- Giving nurses and midwives somewhere to go with their career and rewarding the effort put into further study.
- Performance review in terms of professional development rewards, ie the private business sector. It is not enough anymore to be in a position and not be accountable for your growth. It shouldn't be a job for life. There should also be equitable positions developed to cater for the nursing/midwife researcher, that is nursing research not company data collection (sponsored by a big drug company) but proper nursing collaborative research.



Allow time and opportunities for proper clinical audits, management and research. Allow for the clinician who has forged an academic career but wants to remain in the clinical arena an opportunity to do just that, rather than be promoted away from the patient bedside.

- Need to acknowledge length of service but also knowledge and experience ie just because a person has worked as RN for 9 years doesn't necessarily mean that they have the same knowledge and experience as some one who has specialised in an area for 5 years and whilst further education needs to be acknowledged, those who are transferring their knowledge into practice also need to be awarded - so for example someone can complete a post graduate course but that doesn't make them a nurse specialist - this needs to be demonstrated by their commitment to their unit and the capacity they operate in ie as team leader.
- Finding a balance between remuneration and clinical expertise and level of responsibility/accountability.
- Contemporary approaches - eg collaboration / partnership with consumers, other service providers - ie, interdisciplinary approach; alternative approaches , - ie, beyond medical model , traditional western approaches; broaden skills, depth of knowledge for experiential learning, short term work or change in work focus; recruitment, retention, student mentoring - not good in linking academic, hands on practice, with supportive coaching, mentorship that links all parties - particularly problematic when issues around unsafe practice, students who have not worked before, don't understand HR processes, health related issues (mental illness, crises), students struggle juggling study/work - whole system needs review - better liaison/communication/partnership between all - including training clinical staff accountable / responsible for students; clinical supervision - let's get it into practice consistently.
- I think we need to be more flexible in our thinking about where nurses fit with the health care team. We need to develop roles that enable nurses to move more easily between traditional patient care and the new roles coming up.
- There should be more scope for advancement in areas that are not purely clinical, management or education. Health informatics is an example of an area requiring extensive clinical knowledge and experience but does not easily fit into our current career structure. There should be incentives built into the structure (and this may be an award thing) such as bonuses in recognition of above average performance.
- Look more at abilities rather than pieces of paper. Nursing is becoming overly involved in qualifications and not in the physical activity of nursing.

Responses up to 16 February 2006

- That the monetary reward between levels is sufficient to entice nurses to climb the career ladder. At present there is not enough of a pay difference to encourage nurses into a management role.
- Developing a far greater collaboration/sharing with other complimentary health workers for the end benefit of increased efficiency, reduced cost and better outcomes for our clientele.
- Making sure that we have enough nurses & midwives to care for our patients and have the jobs that we have inherited from other professions such as administrative/clerical/cleaning duties done by the appropriate persons & not by the nurses & midwives. This should mean that we can get on & do what we are trained to do.
- Rewarding clinical leaders, as they are hard to keep in their roles A review of they way we educate our staff, may need non-nursing trainers to work on non clinical skills Getting some ancillary help to do non-nursing tasks, not just carer type roles but admin assistant roles so that if you combine the CNC and NM role that person has some support.
- Encourage development of various roles within their own structure. Strive for professional development and room for advancement in a clinical role rather than having to move into management to gain advancement. Recognition of sole practitioners in the community and the different focus of their work.
- Good leadership, more professionalism. More flexibility and look at new roles and project management. There needs to be a better career path for part time workers.
- Supporting and rewarding those nurses at the clinical level. Currently there is too much emphasis on 'passing accreditation' and 'meeting the budget'. Roles of nurses should reflect nursing not accountancy.
- More opportunities for non traditional roles, community health (it is as rare as rare to have a nurse above a level 2 but often CHN's do activities that if they were in a hospital setting would be a level 3, ie working with community and stakeholders, QI activities etc) and part time workers, there is no career structure for part time work. The whole structure just seems so weighted towards hospital roles and positions.
- The lack of flexibility within the career structure to reflect the multitude of skills and areas of practice within nursing.
- The ongoing problem of promotional positions equating to less monies due to L1 & 2 positions ability to increase income by shift work.
- Supporting nurses as independent, critical thinkers. This takes more then a change in the career structure as it requires nurses to value themselves and their skills and knowledge.



- Make sure level progress is equitable - currently many CN roles are being paid less than their RN1 counterparts who are on a 7 day roster. Recognise the complexity of rural practice and the necessity to make independent decisions with little or no support services.
- That midwives gain autonomy and become practitioners in their own rights. They are NOT nurses.
- Basic education, with a greater emphasis on the practice of nursing, so that graduates actually know what they are getting into, including shift work and less than glamorous tasks.
- Allowing nurses to do the full extent of their nursing practice - not be limited.
- The difference between clinical and management throughout the career path remuneration for post graduate study and for responsibility that reflects the responsibility for peoples lives.
- Move away from the idea that a registered nurse can manage all aspects of health - midwives should manage childbearing and nurses should manage general health, psych nurses should manage mental health, etc.
- Easier to move from one area to another especially if hold postgraduate qualifications in a general area ie. acute clinical care certificate etc.
- This is a difficult one More emphasis on community health when referring to nurses. Too often nursing is reflected as hospital nursing. With the generational health review, PHC and health promotion recognised.
- Pathways that enable combined clinical and management or educational roles at senior levels.
- Staffing levels. How we identify and reward clinical skill compared to management of resources.
- Individual recognition.
- It would be good to focus on primary health care. Develop entry pathways along with promotional pathways
- The ability for nurses to act up into promotional positions The recognition for qualifications obtained but also recognition for clinical experience and non tertiary courses undertaken.
- Nurses/midwives tend to stay within one parameter eg working clinically and as they age within that environment they become stale and jaded. I would like to see encouragement to move across boundaries eg from clinical to community to education, taking relevant expertise and experience with them and learning more along the way. There is very little movement clinically or recognition of skills that are developed over a long time.
- To ensure there is a model of that allows an expert nurse for a clinical specialty to review, assess and evaluate the care regularly in an acute care setting. A process that incorporates the nurse practitioner role. Roles that go across hospital and community.
- More financial support offered to nurses. The nurse today is expected to be a knowledgeable, do further study and be at a masters level for many positions yet little support offered for masters and unless applying for promotional positions no increased pay for having masters or an increased knowledge to others. All units need increased support with Quality, risk management, complaints etc. More project positions or divisional support not one person for entire hospital.
- Rewarding clinicians for their bedside / patient interactions, especially when they are very experienced. There is no recognition of the very experienced clinical nurse. There is no reward for them in the advancement stakes. Advancement for the clinical person is away from the clinical area into managerial roles and not by the bedside where there experience is needed.
- Conditions which attract nurses to become nurses and to remain nurses. Experience is needed in the profession.
- More educational positions, clinical nurse educators for every service provision area within an organisation. Redesign work roles to better utilise skills of professional nurses BUT this must come with appropriate much higher pay scales, higher responsibility should be reflected in pay rates. A CNM/CNC should receive at least \$80,000 PA.
- Recognition of appropriate levels, and responsibilities within nursing practice in today's environment.
- Provide more avenues for clinical nurses. At present a nurse specialist has to do more than a clinical nurse in reference to proving they are working to the level of the nurse specialist as specified by the hospital of current employment. In all speciality areas we are all nurse specialist or clinical nurses as we work autonomously at a greater level in our work practices.
- Expertise in various areas. Ability to function in a multi d team. Recognising individual ability of EN's eg Cert in Workplace Training, Clearer statutory delineation of Diploma EN's v Cert EN's. Nurse practitioners. Accountability.
- Giving acknowledgment to people for knowledge and skills giving them an incentive to advance themselves and take responsibility. This might remove the comment "I don't get paid for it"! Maintaining a Director and Manager position at the same time reducing the management of the ward managers to give more time to the clinical aspect of the position.
- Better training for managers on Risk Management so they understand OH&S clearly and apply it with knowledge and personal caring towards the injured worker. I am aware of several nurses being bullied by managers and this occurs because of a lack of understanding of the Risk Mgt. process.
- Autonomous practice in clinical.
- Keeping the most experienced nurses at the bedside. Valuing experience that nurses bring to their work.

THANKS FOR PARTICIPATING