

CAREER STRUCTURE – Survey Five: Community, Country, Prison Settings, Mental Health, Midwifery, Research, Night Duty and Nurse Practitioners.

Feedback as of 8 December 2006

132 people have accessed the survey and 103 people have completed it. This feedback also includes feedback from respondents at a Mental Health Nursing Summit.

Roles classification	
EN	5%
RN 1 or 2	22%
RM 1 or 2	5%
RMHN 1 or 2	12%
Level 3 and above	48%
Other	8%

Main type of work	
Clinical practice - general	31%
Clinical practice –midwifery	3%
Clinical practice – mental health	20%
Management/Administration	29%
Education/Research	11%
Student/Other	6%

Work location	
Country	34%
Regional city	8%
Metropolitan	58%

Work setting	
Hospital	68%
Community	32%

Generation	
Matures	3%
Baby Boomers	76%
Generation X	21%
Millenials	1%

If there was a fully clinical role at Level 3 and above, what kinds of activities would be part of that role?			
	Yes	Perhaps	No
Developing patient/client protocols?	88%	10%	2%
Contributing to multi-disciplinary protocols for groups of patients?	88%	12%	-
Providing expert nursing/midwifery care?	90%	8%	2%
Providing advice to other nurses/midwives?	98%	2%	-
Making treatment or intervention/ care process decisions about a patient or client's care?	87%	10%	3%
Taking and making referrals?	77%	12%	11%
Working in a caseload model of care?	49%	31%	20%
Working with stakeholders external to health (eg. Schools, housing)?	67%	28%	5%
Working independently (in terms of full authority for decisions)?	70%	18%	12%

Comparison with 'Metro Acute' focus in Article Three responses:

If there was a fully clinical role at Level 3 and above, what kinds of activities do you think would be part of that role?				
	Yes	Perhaps	No	Unsure
Developing nursing protocols for groups of patients?	77%	22%	1%	
Contributing to multi-disciplinary protocols for groups of patients?	77%	23%		
Providing expert input to the patient's assessment, treatment or outcomes evaluation?	89%	10%		1%
Providing advice to ward nurses on caring for this type of patient?	89%	10%	1%	
Making decisions about the patient's care (eg. by doing a nursing 'ward round' for the relevant group of patients)?	76%	16%	7%	1%
Doing elective admissions or pre-operative work ups (including ordering relevant routine investigations)?	54%	30%	13%	3%
Taking referrals from other clinical teams or organisations?	65%	25%	7%	3%
Undertaking outpatient clinics or home visits as required in the relevant field?	58%	26%	12%	4%
Writing up medication charts using agreed protocols?	53%	30%	14%	3%



Do you have any other comments to add about the possibility of fully clinical roles at Level 3 and above?

CURRENT RESPONSES – 6 October 2006 to 8 December (See below for previous responses)

- Level 3 is the meat in the sandwich so to speak, and gets caught between managing staff/clinical areas and management issues. Anytime any one is on sick leave the Level 3 has to fill in to ensure smooth area running if that position cannot be replaced. The role is getting bigger and bigger with uni students needing supervision and direction. More university facilitators need to take a proactive approach and be more available to lighten CNC load.
- I do fulfil a role of Level 3 and participate in our daily tasks.
- Essential that they exist. We need people with clinical expertise to be taking a role not only in service provision but in clinical leadership.
- I think concept of combined clinical / management roles works well in some units and should not be ignored.
- Yes a clinical focus and recognition of preparedness and accountability for decision making is very important. It got eroded before it was developed across all sectors in the last career structure model.
- To be fully clinical we need to look at other disciplines such as the medical system where MO's often work at consultancy level and do no admin, purely see patients and are very well rewarded financially.
- Provide advice and education. Only do caseload if trained in that model. Our bureaucratic system will not allow nurses to work independently like doctors. I thought the CN role was already fully clinical. Why do we need a Level3 role? Must be justified in terms of proven advantages and costs to system, patients, and nurses. Would be good to quarantine management roles and create another clinical career pathway.
- Autonomy is vital, as is being the facilitator for multi disciplinary communication. Educator in field for other nursing staff and community important also.
- I think the concept of any nursing/midwifery role not having a management component is idealistic and too simplistic. The difference is in defining the essential broad management role in the business side of midwifery/nursing and the management principles that are applied during the day to day provision of care by all registered midwives and nurses.
- Must have direct client care role; autonomous decision making re client management;
- Clinical leadership training → provide client supervision depending on needs of recipient;
- Community development and education in community and school setting;
- Role modelling, mentoring, leadership, nurturing; involvement in P/D and training activities;
- Community development and involvement in city activities;
- Involvement in decision making that affects clinical practice; Consultants, change agents;
- QI and research; Not enough embedded research in career needed;
- Interpreting national strategies (and local) as well as standards and facilitating into practise;
- Mentor by audit; Educate; Clinical supervision;
- Representation to other audiences beyond health ; Community education; Consultation roles with/for other govt agencies; Engaged in communities, organisations that can drive change or help to; Promote MH issues;
- Independent practitioner roles: Assessment and prescribing roles i.e. prescribing treatment (counselling, referral options);
- Specialist skills provision i.e. co-morbidity, family therapy, assessments, detention rights;
- Co-morbidity roles, drugs to alcohol, IDSC abilities to detain and convey for assessment and treatment;
- High level of decision making, policy making, sphere of influence;
- Clinical mentorship in an organised manner;
- Level 3 to have the opportunity to remain in clinical, educational researcher of practice; Level 4 to liaise with other community programs and provide information as well as a more senior role of management ;
- Clinical supervision; Leading clinical development; Being up to date on current research; Staff education;

- Clinical work with consumer needs in real time;
- Need to coordinate multidisciplinary team so some managerial role remains; Human resources; Preceptorship ;
- To educate other staff re reform, DOH, issues, recovery, consumer led/run services;
- What were they set out to do? Empower, role models; Leadership – part of the structure that directs service delivery and represents the needs of EN 1 and 2s;
- Developing evidence based strategies/plans/pathways for the clinical areas;
- To be fully integrated part of the system. Clinical supervision (or group) management of area, involved in clinical decisions and standards;
- Would take on more accountability and decisions would be implemented by these clinicians without having to get the OK from medical staff; work across facilities rather than one unit.
- Must have direct client care role; Autonomous decision making re client management;
- Clinical leadership training → provide client supervision depending on needs of recipient;
- Community development and education in community and school setting.
- Role modelling, mentoring, leadership, nurturing.
- Involvement in P/D and training activities.
- Community development and involvement in city activities.
- Involvement in decision making that affects clinical practice; Consultants, change agents; QI and research;
- Not enough embedded research in career needed;
- Interpreting national strategies (and local) as well as standards and facilitating into practise;
- Mentor by audit; Educate; Clinical supervision; Representation to other audiences beyond health.
- Community education; Consultation roles with/for other govt agencies; Promote MH issues.
- Engaged in communities, organisations that can drive change or help to.
- Independent practitioner roles; Assessment and prescribing roles i.e. prescribing treatment (counselling, referral options); Specialist skills provision i.e. co-morbidity, family therapy, crisis assessment, booked assessment, detention rights.
- Co-morbidity roles, drugs to alcohol, IDSC abilities to detain and convey for assessment and treatment.
- High level of decision making, policy making, sphere of influence.
- Clinical mentorship in an organised manner.
- Level 3 to have the opportunity to remain in clinical, educational researcher of practice.
- Level 4 to liaise with other community programs and provide information as well as a more senior role of management.
- Clinical supervision; Leading clinical development; Being up to date on current research; Staff education.
- Clinical work with consumer needs in real time.
- Need to coordinate multidisciplinary team so some managerial role still remains; Human resources.
- Preceptorship; To educate other staff re reform, DOH, issues, recovery, consumer led/run services.
- What were they set out to do? Empowers, role models.
- Leadership – part of the structure that directs service delivery and represents the needs of EN 1 and 2s.
- Developing evidence based strategies/plans/pathways for the clinical areas.
- To be fully integrated part of the system. Clinical supervision (or group) management of area, involved in clinical decisions and standards.
- Needs to be some clearer delineation between clinical and administrative responsibilities.
- Fully support full clinical role shadowing of staff as needed. clinical skill sharing and standardising
- As the complexity of the healthcare system continues to grow and specialisation of healthcare grows the need for nursing clinical leaders is created. The challenge is how to develop and sustain this group of leaders. The focus of nurse practitioners may not meet the needs of some healthcare agencies or the nurses who seek the Clinical leader role. Recognition of the Clinical Leader who is not wanting a NP role is needed, the career path needs to reflect this and our nurses board needs to develop banding of nurses to reflect their clinical knowledge, skills and training.

RESPONSES - to 6 October 2006

- It would obviously have implications for the DON role in picking up the admin component and then has implications for the EO component of EO/DON roles.
- I think that the role could be expanded considerably, but not to get confused with a role that may work as a Rural Nurse Practitioner.



- Level 3 Country RNs are basically doing all of this with out the time to do it eg Basic Life Support Instructors , and Advanced Life Support Instructors Responsible for all accreditation for the Hospital, ordering, On Call(no Life) often.
- The concept of a clinical only RN3 is good but application in more geographically isolated small units would be difficult without major upgrade to both technology and ongoing training to use the technology.
- I think given workforce shortages that case loads should NOT be included in a level 3's role - even level 2's in Mental Health. In 5-10 years time the shortage of specialists will mean those with specialist qualifications will work from a consultation and liaison role (unless in acute care inpatient settings) and if funding continues to NGO's they will be providing the case management.
- Country level 3 roles always have more than one portfolio beneath them. This can be a complicating factor in definitive ideals about scopes of practice and authority.
- Need to think about the issue of line management - if this is a clinical role, do they have supervisory role as well?
- This would be useful in general nursing/ hospital setting. You could have a shared leadership with one person doing more of the admin. and the other doing the clinical. One or both may be part time, or not 9 to 5, may be a L3 leadership team in the ward.
- At this level clinical is not necessarily a general dog's body role. When I currently have a clinical patient load I also am expected to be available in my management role at any time and this is stressful. I see a level 3 clinical role as a good initiative if it is well designed.
- Need to have the clinical experts at the bedside as part of the multi - d team.
- I support opportunities for maintaining clinical skills - in the community in the broadest sense and be recognized for the difference between acute and community.
- There needs to be taken into account the roles of nurses working in community health centres who do not work in a fully "clinical" way and what this means in this setting?
- Level 3 roles almost always involve supervision of other nurses. This is time consuming but it is necessary to develop Level 1 and 2 RNs.
- I am not sure that I fully support fully clinical roles at L3- I do not have enough info yet to judge their value and then what is left to be managed to ensure a quality service is maintained. I don't believe that mainstream midwifery will achieve its professional aims. I cannot divorce these roles from the current designated nurse or nurse practitioner roles. They have a role but not a mainstream role.
- Clinical Nurse Consultants must provide evidence of actual direct patient care to validate practice and account to their clinical ability. "Practice what they preach" principles will ensure the less senior nurses can apply change standards expected.
- Couldn't see this working in reality. It is hard enough now to work clinically and managerially without the access to non-clinical time to think and plan. Let s not go there!
- Much of what was ticked is already done at a level 2 level.
- Clearer delegation of duties so that CN's work as CN's and when they perform higher duties the CNC role should be introduced allowing CN's to work on the ward as they should.
- The quicker they are made available the better.
- Are nurse educators seen as fully clinical roles and should they remain as they already exist?
- With regard to advanced/extended nursing practice - I have concerns that some designated CNC nursing roles may be lost to these system changes. One role that I am familiar with coordinates multiple departmental and hospital programs which could not be dissolved into 'other' nursing workloads or should be recognised at anything less that Level 3 due to advanced assessment required in the position. Coordination of services includes multidisciplinary team involvement of allied health, para-medical, physicians and surgeons. The lack of coordination of these programs will become fragmented. Often these positions are held by nurses with at least 5 years experience in their clinical field and understand extremely well how to navigate the health care sector and health services to be able to provide a continuum of care from acute care back into the community. They do not only manage patients in hospitals but often move between hospital and primary health care.
- A level of autonomy is crucial but must be supported by appropriate "standing orders", policies and procedures. An accreditation process (with annual review) would then ensure the clinical prowess of staff in these roles.

If you have any comments on career structure issues related to night duty positions, please add them here:

CURRENT RESPONSES – 6 October 2006 to 8 December (See below for previous responses)

- Part time positions, more pay incentive, more days off. 10 hour nights are good.
- I hate night duty but I think that mental health work has been shifted to an after hours focus because of double handling and inefficient systems rather than demand at night causing more presentations.



- Night duty is never allocated equitably in that casuals do the majority of the work. You are locked out of the career structure if you do night duty.
- Let the people who want to work permanent nights work them without forcing them onto day shifts. A night supervisor who acts as a supernumerary for an extra pair of hands if needed, yet who coordinates staff and admissions etc.
- There is no career structure if you are working permanent night shift.
- Currently limited administration ie nurse management support at night very isolated, needs addressing.

RESPONSES - to 6 October 2006

- Within country, I think that the extended or advanced RN roles will assist with GP burnout. In time, I think that Rural Nurse Practitioners could take up some of this workload - to another level. There needs to be a commitment to \$ for training and supporting these positions.
- Level of responsibility needs to be rewarded (currently \$10) per night to be in charge of whole hospital + OPD mid etc, with support of 1 EN.
- Country difference N/A.
- They need a medal!
- In our hospital there are NO night duty career structures, all staff are general clinical and there would not probably be an efficient way to have a higher level worker on night duty in practical and funding terms.
- There seems to be little or no opportunity for clinical promotion if you want to work at night.
- I think the introduction of MET teams especially at night has been very beneficial to support ward staff. Core permanent night staff relieve everyone from having to rotate onto night duty frequently however there are always problems with permanent night staff and work performance. I really don't have a cure all answer.
- Night duty RNs should be at a higher level.
- The hospital after hours issues raises significant issues for the seniority & decision making framework.
- That there is provision for junior staff (which make up the majority of night duty staff) with senior staff access. At least one designated senior nurse available for the specialty area.
- The safety of staff driving long distances has not been considered with the 10 hour night shift, with some staff driving along highways with on coming trucks and other vehicles.

Do you have any comments on career structure issues related to research roles and/or research activities?

CURRENT RESPONSES – 6 October 2006 to 8 December (See below for previous responses)

- More time needs to be given to allow this to happen, especially with nursing shortage and bed crisis.
- Always difficult to manage, however imperative that thought be given to clinicians working alongside academics to provided up to date clinical expertise to research processes,
- Research and the real world need to be connected. A few research focus and funded positions across the state could make an enormous contribution. Maybe they are outside of the career structure but are the business of both clinical and educational facilities. It is a shame that significant nursing positions at professorial level have been eroded over the past few years because of the conflict rather than cooperation between industry and university goals. This applies in ATOD, mental health, Research and practice development to name a few areas of loss and erosion.
- Only pay researchers when they have produced useful research - it's called performance management!
- No expectation for research. In the city it is usually an added burden for someone working in a clinical specialty and done over and above caseload. None done in country unless you count writing up special primary health projects - not primary research. Would need further training to do data analysis.
- Research is an important part of nursing/midwifery and either performing research or undertaking research is essential if as a profession we are to improve the care we provide. The importance of the role of Midwives and Registered Nurses undertaking quality research in conjunction with university should be valued in the career structure.
- Need funding and time allocated .All levels need to be allowed and encouraged to participate in research.
- I find it frustrating as a senior nurse that our colleges in other professions have protected office time to achieve the research and teaching needs of their position but nursing lacks the ability to foresee the benefit and protect the time.



RESPONSES - to 6 October 2006

- When does anyone get time to research with current staffing levels and shortages it is all hands working.
- I always think that research is not sold well to rural nurses. It is as written, linked with academic organisations. There would be many opportunities for staff to research how care is delivered in different areas of rural settings. It needs to be kept simple and relevant.
- May be applicable.
- Another responsibility with possibly promised time to do it in that never eventuates.
- Research roles and activities should not be delegated to those only in higher positions, room should be made for those who choose to stay at eg level1 and part time for family reasons but have the skills and knowledge to be part of research activities. R & D days could be part of more levels of workers roles.
- There needs to be research roles in clinical areas, to develop/enhance the link between research and practice.
- Support research in practice.
- Nursing has a poor understanding of 'research' - it is more than just collecting data, which is what most nurses see. Research nursing positions need to be available as part of the career structure to encourage nursing research and so that it becomes part of the 'culture of nursing'.
- Although built into job descriptions realistic time allocation not available. Community Health J&P specs usually include far bigger role than can be met because pressure is there to have statistical output in negotiating funding.
- I think the profile of clinicians in this role is much needed. However, little support in the acute care sector - too busy, under resourced and not financed.

If time were allocated, would you be interested in undertaking the following?			
	Yes	Perhaps	No
Assisting with the conduct of research projects?	66%	22%	12%
Leading small research projects?	54%	26%	20%
Writing up projects or innovations for publication?	47%	26%	27%
Data analysis?	45%	27%	28%

COMMUNITY

What do you think the Career Structure Review should focus on (in Community Nursing), in redeveloping the nursing/midwifery career structure?

CURRENT RESPONSES – 6 October 2006 to 8 December (See below for previous responses)

- Making the monetary reward more of an incentive.
- If the Generational Health Review initiatives are developed then a lot of health care will be delivered in the community rather than the traditional hospital. It will still be a place to meet both primary health care with a population and prevention focus and responding to a range of health needs. The difference will be the model of care delivery: patient/client focussed will expand. I think that community health have felt a bit precious because of lack of numbers (and exclusion criteria for entry into these arenas because of lack of funded positions). Let it grow. Competency maintenance and R& D should form a substantial part eg 1/3 rd of the nurses job description and supported by clinical supervision and facilitated by the professions research opportunities.
- Empowering nurses to deal with arrogant of other health professionals.
- You do work autonomously but get no recognition for that. Also have staff and team/management responsibility. A separation of clinical and management roles would be ideal.
- Must focus on community education and primary health care. Career structure should reflect this and give recognition to autonomy.
- Increase the levels of midwives/nurses in community health so that RN1 and graduates can work in these areas.
- Development of level of accreditation.

RESPONSES - to 6 October 2006

- Maintaining the Level 3 positions in a leadership clinical role but also reclassifying Community Mental Health nurses at Level 2 reflecting in some cases up to 20 + years experience.
- I think there needs to be a focus on strengthening the links between acute hospital and community. Opportunities exist with hospital in the home.
- Yes it would be good.



- Provision of a career structure in Community Nursing, currently Level 3 is it. If we are moving towards primary health care focus and away from acute (to some extent) then there needs to be a career structure in primary health care, currently it only exists in acute and while this continues that is where the focus will stay.
- More recognition for nurses who work independently.
- Acknowledging the complexity of community work (health promotion, community development, liaison, family work etc).
- Clinical versus Line Management Implementation of NP.
- Scope of practice and levels of accountability.
- An entry point development of a graduate nurse program; Leadership for Level 2 positions, Recognition of Community Development work. Notion of 'expert'/extended practitioner for community health. In light of the changes in health to move from the tertiary to primary focus, there needs to be the creation of a role of CHN - generalist within all health services and a pathway for career advancement in recognition of those skills that are different from acute care.
- The diversity of the role in community. The need for recognized leadership. A level one entry point as a career pathway. The role for the nurse in community development and the impact this can have on people's health status (recognition re classification for this area). The need to have recognition for expert practitioner/advanced nursing to differentiate from Practice Nurses. A 'helicopter' look at the need for many more funded 'generalist' community health nurse positions across health services. Better preparation of nurses to work in the community (universities) and the development of Graduate nurse programs. The recognition re retention of nurses that they should not have to spend years in the acute setting if they plan to predominantly work in the community.
- Acknowledgement of the broad role of nursing. Recognition that patient care may not be a component of the role.
- Recognising that Community Nursing is not one area, but has many diverse career roles. Primary Health Care, Practice nursing, in-home care, community midwifery and community mental health are very different areas.
- Recruitment & sustainability of experienced nurses. Workforce of Community Nurses is ageing and there is no pathway for new nurses to move into this field.
- Greater relationships between community nurses and practice nurses. i.e. could be one and the same.
- Creating a career structure in CHN at the moment it is very limited and often nurses in CH at Level 2 take on tasks that would be Level 3 if one worked in a hospital, this is a key disparity in nursing in CH.
- The GP plus program is a good model to work from. The nursing role should be autonomous in this regard with the appropriate supports.
- Social view of health.
- Education in all areas especially basic parenting skills and first aid, therefore possibly reducing the number of visits to A & E departments and Doctors Surgeries.
- Ensuring that nurses working within these settings are recognised for their autonomy. Many of these nurses do have high levels of clinical expertise and also work without the support that an equally clinical skilled nurse in an acute setting has. The career structure must address the nurses working within the community setting who do not have traditional nursing roles i.e a nurse working within a community to develop community capacity and to focus largely on primary health care. There is a very narrow entry field into community nursing and perhaps graduates who never intend working in the acute setting need a direct entry pathway. There is also limited promotional scope as there doesn't seem to be the same classification levels right up to the higher levels as in acute sector. ie entry into community nursing may begin at level 1 or 2 and then promotion only seems to extend to level 3. Needs to be purely level 3 clinical positions available.

If there were five levels of classification for community nursing roles, at which level would you place the following types of work? (Level A is the lowest and Level E is the highest)

	Level A	Level B	Level C	Level D	Level E
RN beginning practice in community/home nursing	53%	32%	11%	2%	2%
Routine nursing care undertaken in a home setting	36%	39%	20%	5%	-
Complex, advanced care undertaken in a home setting	2%	16%	37%	30%	15%
Enrolled Nurse roles	55%	27%	16%	-	2%
Immunisations/ Screening kinds of work	14%	42%	32%	10%	2%
Community development work	4%	20%	34%	28%	14%
Managing individual clients/families or groups independently	1%	9%	31%	38%	21%
Leadership of a nursing or multi-disciplinary team	2%	-	14%	31%	53%



Do you have any comments on appropriate “levels” of different types of community nursing work?

CURRENT RESPONSES – 6 October 2006 to 8 December (See below for previous responses)

- This is difficult to respond to because the matrix is a bit loaded with assumptions. EN can certainly work in community service delivery structures. I think the rewards should be based on accountability of decision making not the type (eg) multi disciplinary team leadership vs managing groups in the community of decisions made within a structure.
- Managing community politics between health professionals deserves rewards.
- Project positions in small country hospitals generally not available. Community nursing lags behind in many areas - eg aged care sector. Also lags behind generally in SA - lack funding and too much project (short-term) work.
- A degree of supervision, leadership and responsibility is required for new staff or less experienced staff. Those with more autonomy require more respect, time and reward for this.
- Highest level should reflect education/change/research in community and reflect ability to influence primary health care outcomes - MUST be autonomous and have autonomy but also work closely with other stakeholders (eg local/regional government).
- Anyone who has to deal with the community politics deserves a medal.
- Needs to be a clear delineation between skills required for certain duties. Needs to be an adequate career pathway.

RESPONSES - to 6 October 2006

- Reclassifying community mental health nurses at level 2 reflecting in some cases up to 20 + years experience.
- The EN depends on the scope of practice of the EN. Community development should be highly valued as it will be this work that relieves some pressure on the system(health).
- Currently level 2 nurses have a huge workload and a lot of responsibility with little recognition and very experienced level 1 nurses do not get adequate recognition for their level of experience.
- I think that more acute nursing in the home is the future, but resources need to be improved with quality monitoring. There is a tendency to forget the acuity when the patient is not in hospital. But I would not want to see Excelcare in the home!
- Initiating and leading work in partnership with other agencies, sectors (education, industry, council, NGO's) - more advanced practitioner - developing networks.
- Levels need to reflect the complexity of the role and the level of responsibility and accountability required for the position.
- Almost all community nursing roles require a degree of autonomous practice and are therefore not beginner level roles.
- Community nursing is a specialised role with diversity of roles, knowledge, skills and complexity of issues arising on daily basis. Needs ability to multi-skill and work as autonomous practitioner.
- More should be level 3 to acknowledge the interagency and complexity -often co morbidity of client presentations.

Do you think the concept of a nursing clinical/professional leader across services/agencies is a workable concept in community? Could such a role be an elected role (by community nurses), or rotated, or appointed? What are your thoughts on this issue?

CURRENT RESPONSES – 6 October 2006 to 8 December (See below for previous responses)

- YES as long as they are not too big and the person could be able to make relationships across the organisation. Project work is not practice development.
- Why not try it, nothing is new so I reckon it's been tried before somewhere.
- Rotation would be great to give more experience to greater number of staff across agencies.
- An across services/agency leader should be appointed after interview and on the best qualifications, experience and ability.
- Yes. Appointed. Must have both clinical and best practice/epidemiology/ research background. Co-ordinate, communicate and effect change.
- I cannot see that community is any different to any other nursing/midwifery workplace. Therefore appointed positions would be the normal workplace practice.
- Depending on the workload and administrative assistance provided.
- Potential is there for recognition of diverse skills. Role could be appointed or elected with the opportunity to change/manage persons in the role.



RESPONSES - to 6 October 2006

- Yes. Appointed or elected. Maybe rotated, but not too frequently.
- No. We have a CEO that is shared between 3 sites Due to Geographical isolation between those 3 sites it is not an effective way to manage. Country needs are far greater / different.
- Up to the individual - each person with their own view.
- Yes I think it would work but think they would need to be appointed on merit (Just cause you are a good nurse you are not necessarily a good leader - Peter Principle stuff).
- Absolutely, this already exists with Principal Mental Health Clinicians in country.
- No, because the types of work in relation to processes are too different and it would be confusing or blurring the lines to much.
- I think a lot of level 2 nurses already do a lot of this work as a clinical leader, it would be good to recognise this role.
- Yes. Appointed (peer election could be part of appointment process).
- I think this is a fabulous idea, working in isolation in the community leads to poor performance. I think the role should be also linked to hospitals within the region, the role should be elected as current DOH employees are appointed but with a fixed term.
- Yes definitely It could be any.
- Believe to ensure professional standards of practice there needs to be strong leadership - this is an area that has let general community health down and contributed to it being viewed as the 'soft option'. Nursing leadership needs to be very transparent and recognised for the broad role it plays in relation to policy, interagency collaboration, strategic planning and workforce development.
- It is a workable concept. I would favour a terms of at least 3 years.
- Unsure.
- Appointed role because of specifics required and knowledge/skills needed to perform role effectively as 'manager'.
- A professional leader across services Gov. and Non Gov and including GP clinics would be fantastic. I would favour an appointed position - not all have the skills to negotiate such a wide ranging position.
- Yes sounds excellent and could put CHN issues on the table instead of always taking a back seat to hospital nursing.
- Need to be appointed depending on qualifications and experience.
- Placing nurses in easy touch with the community has to improve communication and education.
- Yes. Appointed on person with best abilities for the role.
- Really unsure of what this is asking! Do you mean a nurse who leads a multidisciplinary team? This already exists in community nursing. Do you mean a nurse who case manages clients and is wholly responsible for arranging services for individuals, whether it be across disciplines or across organisations/agencies? Or do you mean one clinical leader who is responsible for all nurses across different agencies perhaps like a DON?

COUNTRY

What do you think the Career Structure Review should focus on (in Rural Nursing), in redeveloping the nursing/midwifery career structure?

CURRENT RESPONSES – 6 October 2006 to 8 December (See below for previous responses)

- Rewards for being all things to all people and professions.
- EN cadets. RN training in hospitals.
- Getting more clinical positions not more managerial.
- Should acknowledge multi-skills; responsibility, etc. ie Mid, A and E experience, radiography not reimbursed - same hourly rate for RN9 in aged care/or in one isolated ward at RAH than RNs in country.
- Responsibility - especially after hours. Being allied health referral and co-ordinators. Extra roles within care setting eg OHS rep. Courses attended, admin responsibilities, rostering etc.
- I feel that country nurses are the most underrated nurse in the SA system. They are expected to deal with a variety of complex medical issues on a day to day basis often without medical support. They work long hours - often unpaid, they have limited access to training and education. DONs and CMs of country units are working up to 60+ hours a week.
- Solo practitioners, more health promotion and health screening roles, education roles.



- Bringing back hospital based training to allow placements for these nurses in the real realm / understanding of what they are going to work in.
- Workforce demands, recruitment and retention factors, client demands, special needs of location, flexibility, classification according to level of expertise including clinical practice as well as academic.
- Definite need for an experienced clinical position to manage country health services after hours whilst still having a separate admin support role.

RESPONSES - to 6 October 2006

- Maintaining the Level 3 positions in a leadership clinical role but also reclassifying Community Mental Health nurses at Level 2 reflecting in some cases up to 20 + years experience.
- I think there needs to be a focus on strengthening the links between acute hospital and community. Opportunities exist with hospital in the home.
- Opportunities and recognition for the Level 1 year 9 nurses who have great skills and knowledge but often there are limited opportunities in a small rural hospital.
- I work in management and my role has gradually changed over the last 10 years, that now I feel more like a site manager than DON. I would like to see positions get back to health care and nursing focus for patient outcomes. I spend more time on services staff and maintenance issues, FOI, budgets, politics. The CEO also works over two organisations so is rarely here and I have had to take on additional responsibilities. This is not the reason that I studied nursing, midwifery and psych. I fear that if nursing management positions don't focus on having experienced, qualified people managing patient services rather than all of the other areas, then many skills and knowledge will be lost to nursing as a profession. (Meaning that it will be difficult to get people with knowledge and skills to stay in nursing management positions).
- Recognition of independent practice when no MO on site & minimum staffing levels. Recognition of the diversity required in nursing in country hospitals. Dealing with many areas/fields of work and need to be competent in practice in all of them.
- We had different levels of CNC that never were implemented. However if those CNC's fill EO/DON leave/LSL positions haven't they already made the grade along with Instructors, Accredited Education etc.
- Removing the walls of hospitals to include clients homes and health promotion but increase staffing numbers would be needed to accommodate the travel more vehicles and equipment to support out of hospital care.
- Continuing education standards - money and time to go.
- Provision of a career structure outside that of only a DON of an acute care facility.
- Recognise that general nursing is a specialist field as we have to have a general knowledge over a vast area of nursing not just one confined regular type of presentation.
- The complexity of rural work, independence/autonomy, limited resources etc.
- I think in the rural area there have to be educational requirements inherent in the role.
- Recognising skill level of Rural Nurses. In small country hospitals, there may only be 2 or 3 Level 2 RNs, so most are level 1. However they are expected to have much more diverse clinical skills than a metropolitan level 1 RN who may work in only 1 clinical area. Small rural hospitals demand that their staff are competent in dealing with anything that comes through the door!
- Acknowledgement of advanced skills required. Clearer delineations of roles and responsibilities. Financial reward i.e. EB linked to advanced skills.
- Same as Metropolitan.
- Focus on recruiting more midwives for rural/remote hospitals by remunerating them appropriately. They do this to attract GP's, why not midwives. This may help the shortage. This may mean that the career structure has a higher level for rural/remote midwives.
- Acknowledgement of multi skilling in country and rural hospitals, with appropriate recognition for those skills within the career structure, in the same way as "experts" in city hospitals specialise in specialist departments.
- Providing access to level 3 positions and above that are clinically focussed. At the moment to advance a level removes you from clinical nursing.
- Do you mean rural acute or rural community as there can be a big difference!!!
- More support for level 2 or 3 positions with a clinical role, not rostering and staffing administration. These roles at present are often to backfill executive positions after hours with inadequate remuneration. Often expected to manage issues that have arisen throughout the day without any opportunity to have input into the process.



Do you think the concept of nursing clinical/professional leader across services/agencies is a workable concept in the country? What are your thoughts on this issue?

CURRENT RESPONSES – 6 October 2006 to 8 December (See below for previous responses)

- Rewards for being all things to all people and professions.
- Practice development roles could reach across regions.
- We have very little effective leadership and what we have isn't up skilled or valued.
- Would only want this if it was a clinical position taking referrals across sites. Managerial would be better on site.
- Sharing of professional knowledge - great. Groups of sites can streamline procedures, all be investing in best practice. Share education, trouble shoot etc. But must benefit all sites.
- I think it is a workable concept as long as resources come with the concept. It would assist the country units if there was a country nurse management team who would develop standard policies and procedures and standardise many of the practices through country SA. It would also give support to the managers of the smaller units.
- I think it would be the most financially realistic concept.
- We work on the 80/20 rule here: as more than 80% of MHN's are in metro I don't think it matters about country.
- Yes definitely, especially with the doctor shortage.
- Depending on the level vs the workforce demand workforce depth and expertise vary considerably as do client and organisational demands , needs to be closely monitored and measured.
- Not practical to have a leader with a patient load.

RESPONSES - to 6 October 2006

- Yes, I think it is. Small units need to rationalise available resources and they perhaps need to be looked at as whole units just not in terms of nursing within those units.
- I think that has the potential to work well. Having worked through amalgamations, and in a multi campus situation, it can certainly work well.
- No.
- No. Hard to keep staff in isolated areas hence more will leave.
- Not really within the current structure. New technology would be required as the expert would never be in the right spot at the right time. Local staffing would need to change so the "expert" could provide education to increase local skill base.
- Unless you work in a rural area you do not have the concept of responsibility/expectation of community etc.
- Yes currently exists within mental health.
- It would depend on the size of the community, probably not in large regional cities but perhaps in smaller country towns.
- Yes.
- I think this would need to be dependant on the area and the communication structure well determined.
- Yes.
- To enhance the continuum of care, clinical leaders across sites would be advantageous and certainly workable.
- Depends on distance between sites - it may work in some places, but each area has its own individual issues in this regard.
- Same as metropolitan.
- Professional leaders often have little understanding of the capabilities of rural nurses.
- Yes. With the appropriate use of technology and improvements in IT, it should be able to happen.
- Regional areas could quite easily have clinical leaders who work across campuses. This facilitates sharing of information and encourages a multi campus approach to health service provision.

Please indicate your position in relation to post graduate qualifications and continuing education using the following table (more than one option can be marked):

	Have completed	Definitely intend to do	Might do	Do if delivered locally	Do if support for costs	Do if paid time was available	Not interested in doing
EN Diploma	14%	14%					72%
EN Adv. Diploma (coming in 2007)			13%		12%	12%	63%
RN nursing Grad. Cert./Dip.	61%	5%	5%	5%	12%	7%	5%
RN Grad.Cert./Dip. (health related area)	58%		12%	2%	8%	12%	8%
Masters	20%	7%	23%	5%	24%	14%	7%
Short courses in clinical nursing	44%	8%	6%	12%	15%	12%	3%
Short courses in service delivery/management issues	47%	11%	10%	10%	11%	9%	2%
Short courses in other skills	36%	11%	13%	13%	14%	11%	2%

What are your views about being able to keep up to date, learn new skills, access clinical information and/or networking with other nurses when working in a country setting?

CURRENT RESPONSES – 6 October 2006 to 8 December (See below for previous responses)

- Rewards for being all things to all people and professions.
- It is very important for both the pt and the nurse for ongoing education and support.
- In which part of the day do we manage to do this?
- Important to maintain skills, and keep networking with other nurses.
- All of these activities are expensive for oneself - travelling, course costs and accommodation- as well as difficult for staff to replace you when away. Considerable sacrifice is needed by family also - being married to a farmer is not the same as other workers as they are not independent of your help at many times of the year. This is not appreciated by city folk and those running courses. I have spent \$2-3,000 a year on these activities with little remuneration or recognition - just my own interest.
- Cost, access, time.
- It seems a bit ad-hoc at the moment. Would like to have access to "Best Practice" models. Also education from experts (eg WCH on paed). Clinical nurses need to know that continuing education is valued and supported. Also need sharing of knowledge.
- Education is often difficult in the country regions due to travel, lack of staff to backfill. Web based programs assist in some areas but not all regional area have access to the web that is capable of delivering the program in a timely manner. For example were I live to download the web, just to open takes approx 10 mins. Documents can take hours.
- It is a key area for nurses and midwives to maintain quality of practice and to maintain their professional links.
- Travel to the city for education sessions is not attainable.
- Spasmodic availability ie according to budget, backfill, appropriate information very ad hoc approach, Need to be very motivated independently. Would be great to do nurse exchange on a short term basis metro/country if suits.
- One of the biggest obstacles is the cost of transport and accommodation, both of which we have to pay for ourselves. If assistance was given for the above then greater numbers of us would do more and not mind having to go elsewhere. Having the occasional course or short presented in our towns often falls short of numbers because we do not have the numbers to attend. I love to network I love to upskill when I can but it can be a very expensive exercise for very little gain.
- It is difficult to access information, not easy to attend sessions that require travel, leaving young family members(even for a day). Tiredness becomes an issue with travelling long distances and then working shift work.



RESPONSES - to 6 October 2006

- More courses need to be rotated around the country area to reduce the amount of travel, and make the intended information directly available to nurses not just rely on the hospital to pass it on, it does not always get there.
- Very difficult because of staffing problems, isolation and funding.
- Nurse need to take responsibility for their own education and not depend on the organisation to always provide this. If the organisation is providing then there needs to be compromise or shared payment, for example travel, accommodation, against organisation paying for wages or registration.
- There are many opportunities to update. Peer shadowing, internet, lots of info online. Uni SA library is available to me as I am doing Grad Dip. There is plenty of information available if motivated enough to access it.
- Have no designated educator. The onus is pretty much up to the individual to seek ongoing learning. Not always granted study leave. Very little in-service. Education needs to be drastically improved.
- Board commitment essential. Money not always the problem. Childcare - work life balance - when having to be away overnight. Incidental costs - petrol - wear and tear on vehicle- motel costs and food costs - fatigue due to travel study etc. Lack of ability to apply new skills in local unit as "not on" when the heart attack comes in.
- I think this is important that skill levels continue and there be opportunity to learn new skills.
- Imperative - the breadth of skills required is far higher in country, both technical, interpersonal, professionalism etc. If any of these are not up to scratch the community that the nurse lives within knows about it, so it doesn't just affect their professional life but also their personal one too.
- Need access to more face to face education, networking and mentoring.
- More support in terms of paid time needed.
- It seems to depend on the health unit. Some utilise the limited funding available others don't. Funding for education is always threatened. Keeping up to date is absolutely essential and more expensive.
- Distance from Adelaide major issue - in accessing appropriate workshops etc. Distance apart from other Rural Nurses also issue - video conferencing not a good alternative, teleconferencing has its limited uses.
- It is of paramount importance to continue with updating contemporary issues in health care & nursing.
- Lacking despite opportunities due to staffing, distance.
- Very difficult to keep up to date as courses are metro based. Increased cost for organisation, therefore reduce the number of times attendance is supported. I have had many no's to attending new MH forums and networking due to costs of travel, accommodation and being unable to cover absence.
- Need much more accessible development programs in rural settings for nurses. At present there is just so much emphasis on rural nurses attending updates/courses etc. in Metro. Why are these opportunities more readily available to city people? Perhaps more nurses would be willing to work in the country if they had more consistent professional support. Some on line clinical information/ education etc. is useful but often clinical expertise and development cannot be readily learned from a computer screen. There has been a Community Nursing Network in SA which I believe is not functioning at present. I believe nurses who keep up to date with skills/knowledge, do so to be competent in their scope of practice, and this is why they sign the declaration when registering with the Nurses Board. There are certainly instances though, when nurses are signing this declaration and not maintaining appropriate skills to be completely competent.
- The difficulty is, not only do you need to find the funds (Which all nurses/midwives do), it often means leaving home for days at a time to attend seminars, conferences etc. This requires organising accommodation, travelling, organising families left at home as well as attending, studying and completing set coursework. Backfill for the workers away is often an issue. This creates stress and sometimes tension between staff left to "take care of things" while others are away. Opportunities to network are enjoyed, but are hard to organise because of these issues. Remuneration for time spent at meetings after work hours or attending in-services out of work hours is a step in the right direction.

PRISON NURSING

What do you think the Career Structure Review should focus on (for nursing in Prisons) in redeveloping the nursing/midwifery career structure?

RESPONSES - to 8 December 2006

- Risk and autonomy/isolation.
- Levels of supervision, independence, complexity and community based visiting. Interacting with other agencies such as corrections.
- Same as metropolitan.

- Much the same as community nurses. I have worked in both settings and feel that the issues are similar. Probably prison nurses do not undertake the primary health care that community nurses do.
- More monetary reward with a new structure of pay.
- I think Prisons /psychiatric institutions /Julia Farr is realistically about custody.
- Nurse Practitioner roles, health promotion, health screening, mental health roles. A community focus rather than a hospital style focus.

MIDWIFERY

What do you think the Career Structure Review should focus on in redeveloping the Midwifery career structure?

RESPONSES - to 8 December 2006

- Within rural - not sure if there could be an equivalent RN2 type position for mid in hospitals where numbers can warrant it. Currently it is all rolled up into one, and the RN2 & 3 need to be experts in the lot.
- It should match any other specialist nurse equally.
- Maintain good midwives in midwifery practice.
- Level 1 staff who have very narrow skills and those with a very high level of skills.
- It would be most useful if the career structure somehow promoted midwifery led services in rural settings.
- Encouraging the ability of RMs to work in the areas of skill and not to be mentors and over shadowed by trainees.
- Hospital based training!
- Autonomous practice, community care, no medical intervention unless needed.
- Get back to the real world - midwives need to know how to work on a ward, answer phones, empty linen, give a hand to the other team members.
- Flattening of the structure to respect the autonomous practice of midwives.
- Hospital based training!!!
- Determine clinical position-eg novice practitioner experienced practitioner,-solo midwife vs team of midwives consider call and backup. Identify direct entry, registered nurse/midwife .Consider allrounder eg a/n labour ward post natal etc vs post natal only.

If there were say four levels of classification for midwifery roles, at which level would you place the following types of work? (Level A is the lowest and Level D is the highest)

	Level A	Level B	Level C	Level D
Newly registered midwife	96%	4%		
Midwife working only in a single setting such as labour ward or postnatal ward	38%	42%	20%	-
Midwife working in an obstetric model	21%	50%	25%	4%
Midwifery service manager	8%	8%	32%	52%
Midwife working in a midwifery led model	8%	13%	54%	25%
Midwife working in a caseload model	8%	12%	44%	36%

Are there activities or criteria that might differentiate different levels (for classification not professional purposes) of midwifery practice? If midwifery is a single role level, at what type of classification level (based on current classifications) should all midwives be classified? What are your views?

RESPONSES - to 8 December 2006

- Having trouble slotting rural midwives into the boxes above. GP's manage most of the antenatal care here in their surgeries. I can see there are possibilities for shared care models, but would need a lot of work with our GP's.
- Level of qualification or responsibility (ie Certificate, Diploma or Degree) If only midwife on duty need recognition/reward (in the country need to look after LW, post natal mums & babies all on the same shift as the only RM on duty), not to mention the rest of the ward patients!
- Level 2.
- Almost need 2 classifications: obstetric nurse levels 1-? Midwife.



- If a midwife maintains skills, knowledge and experience in and across the span of midwifery whether that be in a traditional or a caseload model then they are at Level 2. This would include active participation in clinical practice improvement, clinical audit in-service education, skills update across the spectrum. Should they wish to remain within 1 area with no senior functions such as shift co-ordinator, in-service presentation, small research/clinical audit roles then they remain at Level 1.
- Midwives working in a single setting could work towards reaching a classification level C or D if proven to be specialists in their fields or managing their areas. Midwives working in midwifery led models are working at a higher level at all times because of the nature of their caseload and this should be recognised.
- EN.
- Isolation: eg. rural remote Experienced Midwives should be classified as Level C.
- Solo midwife on a shift eg in labour ward and still responsible for post natal , theatre , antenatal.

MENTAL HEALTH

What do you think the Career Structure Review should focus on (in Mental Health Nursing) in redeveloping the nursing/midwifery career structure?

CURRENT RESPONSES – 6 October 2006 to 8 December (See below for previous responses)

- Clinical leadership and practice development Specific performance outcomes attached to senior roles, so that there is a clear expectation that leaders will perform. There needs to be agreement among senior mental health nurses about the leadership roles they will each have across the organisations. EG allocation of the Practice Development role being consistent across Regions.
- Rewarding people who have the tenacity to stay. Dealing with self interest and playing politics.
- Rewarding us for what we put up with and still turning up to work.
- My concern is that once again community appears to be missed in being addressed differently to other areas in the system. Community services can easily be and usually are directed/ dictated to by the local health service management/ policies etc.
- Increased classification of clinical CMHNL1.
- Increased staff development days allowed per year, make a base level of ongoing education mandatory and connect to a reward annual pay bonus. Pay reward for preceptor ship role/ mentoring.
- Statewide reclass – not influenced by whether you are buddies with your CNC or TL.
- Structure level 1,2,3,4 community.
- Administration responsibilities vs clinical role.
- Recognition and remuneration when expected to carry clinical role and be team leader.
- Retention and recruitment x 2.
- That management roles are just that - they 'facilitate' what is required for service to clinicians to do their job.
- Increased clinical path and recognition without management duties or dominance.
- There is a difference in role of the country community MH nurse and this requires differentiation and recognition in classification.
- Flexibility – i.e. other than F/T roles etc.
- Embedding research and quality evaluation in all roles.
- Focussing on broadening roles at all levels of MHNs.
- Ability to have many specialist roles e.g. combined nurses -dementia/delirium nurse, discharge planning, rehab nurses.
- Clinical support facilitator is an oxymoron – Surveillance language is reductionist and dangerous – does NOT reflect care or recovery philosophy – I don't survey, I service, assess, intervene and provide holistic care to clients and their families.
- Education modalities.
- Time to attend training – courses available not always able to attend.
- Look at encouraging autonomous practice in both inpatient and outpatient settings → recognise staff with these demonstrated skills and reward with increased position and remuneration (want MHN's to be more broad with therapies and skills they use in practice).
- Recognition of clinical development skills.
- How to blend a mix of clinical operational functions – L3's need knowledge and understanding of both areas to have understanding of processes which can assist with driving change and improving service delivery, staff development etc.



- Developing more scope for MHN to develop areas of practice – time off and how this is structured into work practices.
- Return of 3 year mental health course (direct entry) – Bachelor of Applied Science Mental Health Nursing.
- Defining mental health, nurse role in health nursing, 'multi D teams'.
- Focus on advanced assessment skills.
- Focus on criteria for detaining mental health clients as this is an area that needs to be visited part in 'community mental health'.
- Focus on psychopharmacology.
- Focus on rehab and recovery model of mental health nursing.
- Direct entry mental health course.
- Clarifying the role of the nurse in multidisciplinary teams in the community as discipline roles are blurred with the only difference currently being that allied health doesn't give injections.
- Base grade should start at level 2 in community with more opportunities to progress to level 3 and 4.
- Practice development nurse level 3-4 in all regions.
- Rewarding the clinical leaders at each level who have taken steps to be proactive in specific expertise, actively extending their practice and accountability (not only by academic education but a variety of means). Recognise their inputs and ability by paid reclassification and not just a yearly increment salary increase. If you are working on an extended level or level of influence or expertise that you should be rewarded and levels below you should want to act in your position.
- Paid overtime for all levels in clinical supervision with back fill.
- Look at diversification of the clinical role and how it could be structured and identified for the individual.
- Look at expertise interests and strengths of clinicians: where will the funding come from is a criteria.
- Level of autonomous decision making (how is appropriateness measured), Measurement of professional development which is shared with colleagues.
- Clinical leadership please!
- Cross referencing consumer service needs with allocation of jobs.
- Retention and industrial issues, wages, role definitions.
- Development of pathways i.e. areas of expertise such as education/management/clinical – horizontal structures.
- KPI and role identification → accountability/autonomy of practice not based on personality or length of service.
- Professional development structured to career advancement not haphazard/specific to area of expertise i.e. education/management/clinical.
- To be purely clinical the level 3 expertise needs to be available to the 1 and 2s twenty four seven. We need them to do shift work.
- Agree with much in presentations, providing pathways that encourage drive and determination (+reward these) encourage that nursing is a profession and has its own standards, checks and balances, that we are mature enough in this profession to support each other and create an environment that is a rewarding one to be in (and that we can promote);
- Reallocation costs for interstate and overseas.
- Making CNCS on the ward actually be experts.

RESPONSES - to 6 October 2006

- I am currently studying in this area and have done some clinical placements. The current structure seems to me to provide a foundation for lots of political debate with staff in RN2 and 3 positions, so certainly needs to change. I think that the career structure within mental health really needs to focus on direct patient/client service delivery so that mental health nurses spend more time with patients. I've seen RN3's doing stores, stats, etc and not spend any time with patients. Shouldn't they be the experts in their field - expensive store people!
- Supporting level 3 nurses, in further education, attending conference(ie encouraging attendance and paying for).
- Providing a career structure in community MHN. Provide incentive to 1.be a clinical supervisor and be in supervision 2. work from a recovery model 3. work culturally appropriately. 4. work from a consumer focus 5. encouragement to work from a primary , secondary and tertiary level of care , not just tertiary.
- More support on a 24 hrs basis not just phone support.
- Skills, expertise and experience, not time in organisation or who you know.
- Inpatient units, supervision provided, independence, level of expertise, complexity of client need. Community, supervision provided, independence, level of complexity, knowledge base, advanced skills, education & competencies for advanced practice.



- On call arrangements for mental health nurses.
- This needs to be consistent to the whole spectrum of nursing and not classified to the union demands. It seems that the classification of nurses is higher in MHN to the general nursing arena!
- More Mental health patients are coming to general hospitals where staffing especially in rural and country hospitals is not sufficient to cater for these type of patients.
- Providing access to level 3 and 4 clinically focussed work roles.
- I would like to think that roles in chronic disease management emerge and are not left solely to varied allied health disciplines. These could easily be established within general practice, NGO's and new GP centres.

What are your views on the best way to incorporate Clinical Supervision/Mentor type roles and Practice Development roles in a career structure?

RESPONSES - to 8 December 2006

- Through the EBA so management has to support and not just give lip service.
- Following my comments from above, working with patients/clients and closely with other staff may facilitate changing the culture in mental health and improve clinical practice and patient outcomes.
- Through the EB agreement with an expectation that organisations will provide opportunity for this to exist.
- To have a clinical specialist/consultant role. To incorporate clinical mentoring into CN role.
- Mentor type roles also need to work across campuses. Certainly need to be more available for acute settings and need to be 24 hour 7 day per week service.
- Clear leadership relevant to specialisation of practice is paramount to be successful in this role.
- Financial commitment and support by organisations, face to face is best.
- Have them as distinct roles in the Career Structure and in organisational structures. If this occurred, the roles would have a scope of practice that is not only nursing orientated, but also system change orientated. To achieve practice and cultural change, these positions need to have "authority" in an organisational structure.
- Clinical supervision should be part of the job to have and to be supported with time and resources to provide CS. Practice development roles need to be at 4 or higher.
- The Nike principle - Just do it!
- Just add it on like everything else is?

Do you think community based settings – either in community teams or managing residents in a community house – and institution based settings create opportunities for different roles and/or classification levels?

RESPONSES - to 8 December 2006

- All community mental health nurses should be at level 2 reflecting in some cases up to 20 + years experience of many of the nurses currently doing this work many with advanced qualifications post graduate Masters and above.
- Given I work over 2 rural acute settings, I think there are many opportunities to strengthen links between acute and community settings. Subject to geography in rural areas, why can't community mental health nurses have more involvement with patients in the acute setting and work with other nursing staff in hospitals by being mentors and support people in mental health.
- Yes- levels of autonomy of practice should be recognised as well as levels of consultation and liaison provided.
- No, often those in the hospital setting have to continually deal with the higher end difficult situations regularly rather than as a support role in the community. crisis situations always end up at the hospital especially in country.
- Yes x 4.
- I think it does given I have spoken to a number of community nurses and value their contribution.
- Positions of responsibility should be acknowledged.
- Yes, community allows for more autonomous practice, if and when it is supported.
- The setting should not dictate the skills in relating to people and delivering client focussed mental health care. It worries me that the old concept of 'danger money' might be brought back in!
- Yes, people who work in Supported Residential Facilities are generally not nurses but are asked to do the work of what would otherwise be nurses because our society has marginalised these people.

If there were several levels of clinical positions in mental health, what activities/roles etc do you think would differentiate levels? Or, in other words, what are the differences between say a novice, advanced and expert mental health nurse in terms of activities they undertake?

RESPONSES - to 8 December 2006

- Experience, and whether the nurse wanted to follow the clinical pathway or community development pathway or indeed the management of teams pathway.
- I am an advanced RN but about to be a novice mental health nurse. What I would want is to have more experienced nurses who can be mentors, support, advice etc.
- See the ANZCMHN guidelines, they set this out very clearly.
- Experience has to be considered.
- Ability to assess mental state, ability to mentor, ability to work with families, ability to resolve conflict. ability to work across disciplines, ability to work across practice settings.
- I use the basis of accountability & responsibility in the role as the difference. That is, although we are accountable in our day to day practice, I believe the level increases with leadership and acquired skills in the role.
- As the research suggested (all the way from Benner) the better your knowledge, qualifications and practice the higher a level you should be able to undertake.
- Senior clinical positions need to not only have clinical expertise, but to also have a level of political and strategic 'savvy'. It is no good being an expert practitioner in an area if you can't advocate on all levels for clients with that clinical issue! This has been overlooked in the current career structure in my opinion.
- The difference is about the complexity of decision making and accountability for outcomes.
- Novice = new advanced = not so new expert = not new at all.
- Responsibility levels for clients, mentor roles, clinical experience/expertise/qualifications-academic and clinical.

At the Mental Health Nursing Summit session, the question above was asked as follows:

What criteria could be used to differentiate different classification levels in terms of EXPERIENCE?

RESPONSES

- Time/experience in the role, ongoing commitment to receiving staff development.
- Demonstrated competence.
- Advanced practice in area of specialty and or sub specialty, i.e. aged care mental health.
- Demonstrated performance in skills, knowledge, qualifications; Key performance indicators; Expertise in RN area.
- Years of experience; overall diversity; Range of exposure to work environment.
- Essential – nurses need to demonstrate and articulate increased experience that is of value to patient care.
- Experience across multiple areas/roles.
- Focussed experience within areas of specialty.
- Diverse roles that have developed skills in numerous areas of practice e.g. clinical supervision, self development, practice management.
- Should be considered but looked at closely so that it is not just length of time served but actual work and role and ability displayed.
- Probably should be done on a one to one basis not just a generalised system.
- Progression predicated on time in position entry level only for probationary period.
- Demonstration of competence;
- At least 3 years of lower level and 5 years for senior management but I really believe that experience should only be a minor differentiation.
- I have had vast experience in both general and mental health care: I understand the principles of holistic care of my clients and have the experience as a Team leader and appreciate the multidisciplinary approach to client care.
- Evidence that a person is open to new ideas, learning (not necessarily academic) variety of experience, not necessarily mature (not necessarily old) attitude to develop each other.
- Broad range of clinical experience with evidence of ability in applying skills learnt in one area transferred to another.
- On top of a broad range of clinical experience – then evidence of specialist skills in an area of work e.g. specific client group, clinical issues etc.
- The entry point for new workers is the clinical end so these roles should be valued more perhaps by having level 3/4 positions doing some as well part time to other roles of staff education and other planning of the big picture stuff.
- You can work in an area for 10 years as a level 3 does not mean you have up to date knowledge and skill.
- Evidenced practice – not length of practice.

- Broad (different areas) of managing complex clients, managing staff, service delivery, being involved in different areas of quality, peer supervision, previous senior experience (i.e. not been level 1 then 2 for short time).
- Done well in performance reviews, thinking in an innovative way.

What criteria could be used to differentiate different classification levels in terms of EDUCATION/KNOWLEDGE/SKILL?

RESPONSES:

- Time/experience in the role, ongoing commitment to receiving staff development.
- Demonstrated competence.
- Nurse practitioners should be L4.
- Base education level.
- Demonstrated sharing of knowledge with students and new clinicians.
- Masters level → commitment to ongoing education as a lifetime pursuit.
- Qualifications Bachelor, Masters, Grad Dip, specialist certificates, Honours, Research degrees.
- Recognition both at academic level/ clinical level.
- Essential – Nurses need to be encouraged to advance education, knowledge and skill - this behaviour can be supported by increased remuneration.
- Continues to educate self and others on specialty and across a range of areas i.e. Uni, workshops, skill base sessions;
- Reflects on practice to improve skills, consults widely across fields, areas practice.
- Definitely should be considered – nurses are not acknowledged or supported with further study, courses are expensive! And not reimbursed (recent qualification allowance does not go far) Portfolios could help with this also.
- Qualifications.
- Ongoing studies undertaken.
- Credentialed Mental health Nurse (ACMHN).
- Expert knowledge and ability to impart this knowledge to all levels.
- Evidence of ongoing training and development for all levels relevant to area of practise and ability to impart it.
- I have always pursued further education as I believe knowledge is power and enhances my clinical practice and enables me to share knowledge skills and experience with my peers. I have a Masters degree in mental health nursing and I believe the research component of this degree is very useful.
- Masters prepared with evidence of involvement of ongoing professional development – including research activities.
- An important factor.
- Application of knowledge; Innovation; Understanding current issues and motivated to do so.
- Doing further education – needs to be aware of opportunities.
- Skill mix that encompasses ability to multi task, supervising staff overseeing role of others case load, ability to manage risk and work on clinical improvements

What criteria could be used to differentiate different classification levels in terms of DEMONSTRATING GOOD QUALITY WORK PERFORMANCE?

RESPONSES:

- Time/experience in the role, ongoing commitment to receiving staff development.
- Annual appraisal.
- Regular auditing of case notes; Regular client survey re quality of service.
- Mentor/preceptor to staff experience and novice; Leadership in professional practice.
- Specific KPI, objectives and tangible outcomes.
- Sound and varied clinical experience, effective proven clinical skills, willingness to share.
- Development of resource criteria within unit/hospital environment.
- Clinical leadership participation.
- Essential – Quality care = safe care.
- Increased utilisation of electronic clinical information systems and EHR's can support care and decision making for nurses.
- Utilising evidence base research to uniform practice; Utilising systems in place to monitor outcomes and having understanding of how to present information to improve outputs/outcomes.
- Mentoring, guiding other staff.
- Absolutely! Quality assurance and clinical supervision are extremely important and unfortunately lacking in nursing. This could be a much tighter process and offer support and encourage nurses to perform at a higher level than currently expected.
- Performance reviews, KPI's, 360 degree reviews; Evidence of leadership.
- Proactive involvement in protocols, initiatives to improve client case in the workgroup (making a difference).

- I believe feedback from my clients, management and peers are a benchmark of how my work performance is progressing and is necessary for me to measure my performance.
- Commitment to value other nurses professionalism.
- Evidence of how the individual implemented/interpreted the competencies for that particular work site.
- Evidence of the individual implementing system wide changes/involvement in profession wide activities.
- Actually doing what was expected! Transparency.
- Performance appraisals that empower/support staff and also precede boundaries around practice of EN, RN and students (all encompassing). Opportunity to partake in research, go to conferences, and represent SA. Increase mental health care on the ground – portfolios.
- Demonstrated capability of managing workload well.

NURSE PRACTITIONERS

What do you think the Career Structure Review should focus on in terms of Nurse Practitioners, in redeveloping the nursing/midwifery career structure?

RESPONSES – to 8 December 2006

- I see lots of possibilities for nurse practitioners in rural settings, particularly for managing a lot of after hours outpatients etc. Triage 4's and 5's. I think that to maintain credibility, there needs to be stringent requirements for nurse practitioners to have that label and role. (Needs to maintain the tertiary requirements).
- Further enabling organisations to make opportunities for these roles.
- Developing ward based clinical roles that directly impact on patient care and outcomes.
- Standardisation of the term - are we all talking about the same concept??
- Adequate remuneration for skills. Research and teaching responsibilities Consultant type fees in some settings.
- This would give the nurse a specific specialised role with recognition, authorisation & clinical focus.
- Acknowledgement of Hospital trained nurses with 30 plus years of training being recognised as skilled even without uni qualifications.
- More positions and more support made available to help nurses achieve these roles.
- Recognising that some Community Health Nurses may be working in very similar ways to a Nurse Practitioner.
- There is some concern that NP roles should not sit in the acute sector. I believe currently in this state there are very few individuals with the expertise and experience sitting in Primary Health/Community settings to fill these positions. Even without the individuals, organisations are not recognising the value of the position. Many of the NP candidates may come from the acute sector - they may start in acute and move into transitional or community positions. The emergency departments for example have incorporated the role appropriately and are using such roles to their full capability ie. prescribing, referring, admitting etc.
- NP should be remunerated at a higher level than level 3.
- There are heaps of nurses already doing this who can't be bothered going through a lengthy process at the NBSA to tell them they can do what they have been doing for the last 20 years anyway.
- Nurse practitioners need to be a focus, especially in the rural and remote areas where GP access is not always available. Area where they can be used includes A&E and Aged Care.
- I am unsure about nurse practitioners. We currently have many 'expert' nurses who provide comprehensive care in their area of practice. These practitioners already teach, mentor, lead their colleagues in their practice context. I'm not saying this shouldn't be acknowledged, but is the Nurse practitioner role the way to go? I think there is the potential to "individualise" the profession with the advent of so many Nurse Practitioners. After all, there is no 'I' in team, and isn't this a philosophical position upon which the profession is based, ie team work?
- NP should be remunerated at a higher level than level 3.
- Wake up to the fact that there are heaps of nurses already doing this and can't be bothered going through a lengthy process at the NBSA to tell them they can do what they have been doing for the last 20 years anyway.
- Nurse practitioners need to be a focus, especially in the rural and remote areas where GP access is not always available. Areas where they can be used include A&E and Aged Care.
- By making it more acceptable. In country, CEOs always look at the dollars first and not the outcomes. GPs in country still see the role as a threat. The role needs more exposure and needs to be part of the new career structure. Should be as an appendage to nursing not above or below the level 3 position as it looks at present as undermining and devaluing that position.
- I feel the issue of being an extended practice nurse who is not a Nurse Practitioner has been overlooked in the career structure. The career structure appears to articulate the rise of a nurse in the management of ward issues but fails to find structure for the nurse in the clinical area who is clinically advanced. Nurse Practitioners need their own banding and needs grades in the banding to reflect shift working NPs and years of practice.



Many writers describe Nurse Practitioner roles as being advanced and/or extended nursing roles. What do you consider to be “extensions” to the nursing role?

RESPONSES - to 8 December 2006

- Having trouble slotting rural midwives into the boxes above. GP's manage most of the antenatal care here in their surgeries. I can see there are possibilities for shared care models, but would need a lot of work with our GP's.
- I think that extended roles are RN's who have done some advanced courses ie IV cannulation, ALS, intubation, trauma management. I would see that generally they RN's with add-on bits.
- Nurse /Midwife/Prac.
- Ordering tests, prescribing, referrals to other specialists, admitting rights etc.
- Assessment and treatment planning consultation liaison mentoring research.
- Being able to provide expert advice and education to patients and staff.
- Coordination of multi -disciplinary services advanced clinical skills that are both medical and nursing ie suturing, minor surgical procedures.
- I believe many of the so called "extended roles" are what nurses can (and should) be doing now. Limited prescribing and some referrals may fit into this area.
- Authorising and interpreting pathology results; prescribing.
- The NP provides a holistic approach specific to their scope of practice authorised by the NBSA and that is the difference to their roles.
- Extensions are the management roles that impinge on providing clinical care and focus.
- Fields of expertise where a nurse works unsupported and in isolation from medical practitioners or does not access medical practitioners for certain problems. The Nurse Practitioners are trained and as adept as a Doctor in treating certain conditions. For example - a nurse who is a wound care expert and actually advises medical staff in this field of clinical expertise.
- Advanced assessment, Ability to prescribe medications, Autonomy to admit to hospital, refer to other services and specialties and to order other investigations/pathology. Involvement in nursing research, Mentoring and succession planning, Education, Collaborative practice.
- I believe that any role can be seen as extended when the incumbent is involved in broader activities pertinent to their role. eg an expert clinician who provides expert service provision, who advocates for changes to the context in which they practice, who demonstrates applicability of research in practice, who participates in wider forums regarding their practice context, and who can demonstrate change in practice in others around them.
- Authority and ability to determine and deliver interventions.
- All with written guidelines and policies to protect and support the worker; ordering pathology, x-rays medication dispensing and scripts, writing medication charts especially in the rural aged care facilities. Sick certificates including WorkCover.
- Autonomy, prescribing, extended scope of practice.
- This is a dangerous question as it can be answered only in the here and now. What were seen as extensions to nursing are now common practice, what is now an extension may quickly become common practice. In general an extension role may include: independently prescribe medications, order and manage the results of screening and diagnostic tests, perform minor surgical and invasive procedures, manage patient/client populations.

If you wish to be a 'Nurse Practitioner' and/or a nurse working in an extended role, what would assist your development to get to that point?

RESPONSES - to 8 December 2006:

- Someone that could consult about the best direction to take with tertiary study to reach the goal. Financial support is often an issue to people undertaking tertiary study.
- Funding time and kept promises.
- Organisational support for the role - or at a minimum understanding of the role.
- Mentoring research further study.
- Incentive to study time and or money.
- Some advice on educational requirements to pursue the role even if it may be some time in the future.
- Education focussing on pharmacology etc to cover those areas.
- Support from management in terms of time and/or study leave.



- Comprehensive competencies in the specialised area of nursing practice, continued application of nursing practice, and suitable education to enhance practice. I would encourage Masters level from post graduate specific skill.
- In house training and acknowledgement and support.
- Organisational support, financial support, able to take study time, not being short staffed in area of work.
- Accessible study programs.
- Education to enhance practice. I would encourage Masters level from post graduate specific skill.
- Some-one else to go through the application process on my behalf and write it all up.
- I consider myself to be currently working in an extended role, particularly when I compare the activities I am involved with those of my peers. However, having already completed a masters degree in the area I practise (7 yrs ago), and having developed new practice protocols, and continuously participated in advocacy activities, and leadership training programs, and always participating in organisational change activities, I have no intention of jumping through the hoops that is the current nurse practitioner accreditation process! What would be the point?
- Clarification of the role across mental health settings
- I feel most country RN work at a Nurse Practitioner role in their day to day duties. The main development they would need is the support of the Medical Officers and the organisation to develop procedures to protect the nurses. I also think that the country nurses need to get the respect from their city peers, how many city nurses in a day would attend patient care, attend pathology, insert IVs, do X-rays all without any Medical officer in town.? Country nurses also have to stabilise critically ill patients often without Medical Officers prior to the retrieval team arriving.
- Supported learning both with costs of course and costs for time off to study and backfill for our usual position.
- Credit for prior practise understanding of clinical skills already utilised. financial support, peer support.
- Clear descriptions of what it means to be a NP or ER nurse. Clear understanding of what the reward would be for attaining the NP or ER role. Clear documentation of the requirements to meet the needs of the NP or ER role. Documentation for others who need to support you in achieving the role, line managers, supervisors, other health professionals and the community.

If there was more than one single classification level for Nurse Practitioners and/or expert nurses, what kinds of role activities or other factors would differentiate one level from another?

RESPONSES - to 8 December 2006

- It may get down to the range of qualifications that they have in different areas ie mid, psych, general, acute, emergency, trauma, ICU.
- Similar to other areas where things like - working across multiple sites , organisations , etc are recognised.
- ?? level of expertise.
- Advanced or newly registered.
- Should not be differing levels x2
- Acknowledgement of hospital trained nurses with 30 plus years of training being recognised as skilled even without uni qualifications.
- Involvement in the acuity of care, extended research roles, management roles focus.
- At present this is tricky to answer. Perhaps a nurse who has studied more than one field of expertise would be recognised at a higher level than a nurse who only has one level of expertise.
- 1. Prescribing, admitting and referral rights 2. Involvement in evaluative research/scientific research 3. Coordination of State-wide services i.e. no of organisations providing services for.
- Educational preparation and continuing competence and experience.
- Would that mean we would have to go to the Nurses Board more than once! (Answer from Project Officer – no. NBSA has nothing to do with employment classifications).
- I would expect a Nurse Practitioner to be an "expert" in clinical hands on nursing, where an expert nurse could be in any field including research etc. The Nurse Practitioner would be the doer and the expert nurse be the teacher (although they would interchange at times).
- Scope of practice, clinical experience.
- Base level - able to perform advanced procedures (research Activities) Second level - base level + manage pt populations Third level - Level 2 + order and manage tests 4th Level (NP) - Level 3 + prescribe medications (manage multi research).

THANKS FOR PARTICIPATING