

Where are we now? Context Issues

This is the first in a series of articles to encourage discussion and feedback about nursing and midwifery career structures in South Australia. Each article will look at a different group of issues affecting professional career structures. It is hoped that these articles will stimulate workplace discussions, challenge nurses and midwives to ask further and deeper questions, and become a way of collecting feedback from as many people as possible. Your views are not only welcome, they are crucial. Thinking about these issues and finding out what nurses and midwives are thinking is an important first step. The next step will be to develop some options for a new career structure.

Background:

This Project is the result of an agreement made between the Department of Health and the Australian Nursing Federation to review the professional career structure as a basis for negotiation of the next Enterprise Bargaining Agreement (EBA) in 2007.

The Project will use the term 'Career Structure' to refer to a professional framework that balances the needs of health service organisations to deliver nursing and midwifery services and the needs of individuals to have a framework within which they can aspire to move into different levels and fields of work. Such a framework is in part used for salary classification and allowance purposes but is much more than that. While the outcomes of this Project will be used to frame EBA arguments for classifications, the Project itself is mainly about clarifying

and developing the professional framework rather than the industrial application.

The term 'career pathway' describes the decisions and choices made by individuals as they make their working life journey. A career structure in the public sector (the focus of this Project) is one part of the range of options open to those embarking on a nursing and/or midwifery career.

According to key stakeholders in the 2001 National Review of Nursing Career Pathways Project, career structures and/or pathways should deal with a range of issues such as:

- Workforce needs and effective and efficient use of the total nursing/midwifery workforce;
- Describing nursing/midwifery as an attractive, diverse and skilled career choice for both genders and multiple generations;
- Integrating nursing/midwifery with other parts of the health work force;
- Taking account of the interrelationships with other health professionals;
- Ensuring that nurses/midwives are encouraged to practise to their full professional capacity;
- Matching skills and expertise to the work required in the particular workplace;
- Identifying the diversity of nursing/midwifery roles, including functional roles within and outside the health system;
- Having nursing/midwifery professional skills and knowledge recognised;
- Supporting emergent roles such as Nurse Practitioner roles;
- Being flexible enough to accommodate individual life experiences, access to

information, personal decision-making; professional development; choice and emergent changes to health care systems;

- Organising, linking and showing the need for, and importance of, specific and ongoing education and training;
- Ensuring time for nurses and midwives to 'care' for their patients;
- Providing nurses/midwives with some control over their work;
- Providing employment opportunities;
- Being responsive to the health care needs of society;
- Incorporating Australia's cultural diversity; and
- Preventing the reductions support services to nurses (supply, clerical, human resources, cleaning and food services) with experienced nurses spending more time undertaking tasks that take them away from delivering nursing care (Price 2001).

That's a lot of expectations! The range of these views indicates something of the challenge of this Project.

***The Project's Main Question:
What kind of structural model can be used to best balance effective nursing/midwifery care delivery to clients and the career aspirations of nurses and midwives across public sector contexts of practice in South Australia for the years 2007-2027?***



The 1986 Career Structure:

The current SA Career Structure came into being in March 1986. At that time, the major goal was “the need to retain competent, experienced nurses at the nurse-client interface” (Silver 1986a). Nursing education, management and research were considered “essential to the delivery of quality patient/client care” but were considered to encompass nursing’s “secondary functions, not its primary concern, nursing practice” (Silver, 1986a).

The objectives were to develop a structure which would:

- Facilitate career advancement for clinical practitioners as well as nurse managers and educators;
- improve the standards of patient/client care by introducing and advanced clinical role;
- Promote devolution of authority and legitimate power;
- Reduce spans of control;
- Decentralise decision making;
- Increase accountability at each level of practice; and
- Provide status and remuneration equity between practitioners of the same level in different fields of practice” (Silver, 1986a).

Figure 1 summarises the old and new structures of the time.

The 1986 Career Structure was based on study of then current nursing and management literature and was influenced by Patricia Benner’s nursing interpretation of the Dreyfus ‘Novice to Expert’ skill acquisition model. Dreyfus suggests one passes through the proficiency levels of: novice, advanced beginner, competent, proficient and expert, in the development and acquisition of a skill.

The structure with its five salary levels based on the Dreyfus model of skill acquisition is demonstrated in Figure 2 (Silver, 1986b).

Pre 1980’s Common Structure	New 1986 Career Structure
Matron or Director of Nursing	Director of Nursing
Deputy Director of Nursing	Assistant Directors of Nursing
Nurse Supervisors (areas)	CNCs/Nurse Managers/Educators
Educators	Clinical Nurses
Charge Nurses	Registered Nurses
Registered Nurses	Enrolled Nurses
Student Nurses	
Enrolled Nurses	

Figure 1: Comparative nursing structures

SALARY LEVELS				DREYFUS MODEL OF SKILL ACQUISITION
Level	Desirable Qual.	Yrs Exp	Comp	
5	Bachelor UG1	10		Further broad and specific knowledge and skills, analytical and decision making ability LEVEL V - EXPERT BARRIER
4	Bachelor	6		
3	Bachelor			
4	BARRIER			
3				
2				LEVEL IV - PROFICIENT
1		3		
2	Post Basic UG2 or Spec. Cert			
1	BARRIER	3		LEVEL III - COMPETENT
2				
1				LEVEL II - ADV BEGINNER
5				
4				
1				LEVEL I - NOVICE
2				
7				ENROLLED NURSE
6				
5	BARRIER			
4				
3				

Figure 2: The Dreyfus Novice to Expert model applied to nursing in South Australia



In 1999, a call was made to review the career structure in light of "some of the major issues that have emerged as problematic since implementation". These issues included major changes in the structure of health care organisations and in their financing; the inappropriateness of the single structure for community nursing services and country health service settings; fiscal pressure that had limited and

eroded promotional opportunities and the clinical expertise availability proposed in the structure; and over time the ambiguity, lack of clear role definition, increased spans of control and role overload that have threatened the original proposals for roles and career opportunities (Koch, 1999).

The following table that outlines the current professional and

industrial structure of public sector nursing and midwifery indicates that rewards (mostly financial) may result from a combination of promotion; responsibility; the size of the employing organisation; years of service; qualifications and training; personal reclassification criteria; and/or the time of day, or day of week worked.

Common Title		Award Classification Title	Salary Level	Means of Achieving that Level	
EO/DON		RN/RM Level 5	5/6	Role/size of organisation	
			5/5	Role/size of organisation	
DON		RN/RM Level 4	5/A to 5/E	Role/size of organisation	
Nursing Director			4/3	Role/size of organisation	
			4/2	Role/size of organisation	
		RN/RM Level 3	4/1	Role/size of organisation	
CNCs/Managers/Combined Clinical Managers/ Educators/Nurse Practitioners			3ZC	Role/time of day	
			3Z	Role/time of day	
			Band C	Role plus conditions	
		RN/RM Level 2	Band B	Role plus conditions	
Qualification allowances added in RN/RM Level 1, 2 and 3 only, and EN with Diploma			Band A Thereafter	Time	
			Band A Year 1	Role	
			Year 2 to 4	Time	
			1	Role	
			RN/RM specialist	Year 2-5	Time
			Year 1	Meet criteria	
		RN/RM Level 1	Year 2-9	Time	
EN Diploma entry	Year 2-7 Time	EN Certificate Entry	Year 1	Degree Entry qualification	
	Year 1 Entry qual		Point 7	Additional study	
			Year 2-6	Time	
			Year 1	Entry qualification	
Undergraduate Student		EN Cadet		Role	
			Over 21	Role and age	
			Under 21	Role and age	

Figure 3: Summary of career structure and industrial classifications in 2005

Other salary benefits not related to role and/or skill level (below Level 4) include: PDOs (EN; RN, RM Level 1/2 only); Shift allowances; Zone allowances; On-call allowances; and Hyperbaric allowance.

As you can see, over the last 20 years, the 1986 career structure has become a complicated mix of professionally based framework (rewarding roles and education) and rewards that are not related at all to a career path (such as the

time of day one works). After 20 years we probably need a new framework! But what should it look like? What are the best things in the current career structure? What should we change and what should we keep?



Contextual Change:

Lots of things have changed in 20 years – for some of you, these will be part of your own experience. In the mid 1980s health service organisational change was slower and separate changes were more distinct compared to the constant and overlapping change we experience now. Fewer processes are predictable and a sense of uncertainty and frustration has increased.

The focus on budget management dominates over all other service indicators. Information and documentation are increasing but hospital IT systems are under resourced and often slip out of date.

In the eighties most nurses/midwives were fulltime and agency work was mainly seen as a short term option to save for travel. Now part timers make up about 40% of the nursing/midwifery workforce and agency work is a career option in itself.

Despite an age range in the eighties, the majority of nurses/midwives were 'baby boomers'. Today there are three distinct generational groups – particularly in acute care nursing – and each generation has different ideas about work and career.

Post graduate university study and other forms of formal continuing education are now the norm rather than the exception.

There are increasing numbers of internationally qualified nurses and midwives in South Australia. These changes, more movement of nurses and midwives and access to internet information bring a wider range of ideas into practice.

Team approaches to health care in the 1980s generally meant that the medical consultant was the team leader (although rarely present in the ward). Nurses functioned largely as adjuncts to and implementers of medical care.

Now new models of care delivery – both within nursing and midwifery and across health professions generally – are developing and new technical roles are emerging. Historical models of service delivery and medical education are deemed to be no longer sustainable, nor flexible enough to meet constantly changing organisation needs.

The patients of the eighties were generally passive recipients of health care. In 2006, consumers of health care services are more informed, and have higher expectations of individual, immediate and best quality care. An increasing number of our clients and their families – as in society in general – express their dissatisfaction through aggressive and violent language and behaviour. Health care has become increasingly politicised and subject to litigation.

The South Australian Health Commission (SAHC) of the eighties held more central control over hospital structures and workforce models than the current Department of Health. Less central control has given opportunities for more flexible options but comes with increased fragmentation.

So there has been significant change since our current career structure was developed. How do these changes impact on the way nursing and midwifery should be structured? What changes can we expect in the future?

The Future Context:

The Generational Health Review (2003) has focused on responses to health delivery challenges in South Australia. Implementation of the Review's recommendations will lead to the following changes. Resources will be linked more to population needs than to institutions. Budgets – having moved from historical to Casemix - are set to move to population based criteria.

It is intended that services will be networked rather than attached to single hospitals or organisations. There is a desire to increasing the multi- disciplinary nature of work teams and shift from what is considered a service focus to a consumer focus.

The processes of the Project will be based on six principles:

- Appreciative inquiry;
- Strategic questioning;
- Future focus;
- Systems thinking;
- Public conversation; and
- Reflection and learning.

Learn more about these principles at www.nursingsa.com/prof_career

The dominance of some areas in current service delivery arrangements is believed to need rebalancing. This philosophy would see a balance of Statewide consistency with local flexibility, of budget certainty with budget flexibility, of community based care with acute hospital care and of competition and collaboration.

While many nurses and midwives might wonder how such changes might be achieved and whether the outcomes will be as planners intend, there is no doubt that there will be major structural changes ahead in health services.

These changes have potential impacts on the way nursing and midwifery are organised. Will there be more flexible roles across hospital and community services?

Will new chronic disease services provide opportunities for nursing and for different care team structures? Might budget flexibility mean more opportunities for nurses/midwives to try innovative care models? Will some services change location? Might the co-ordinating and integration skills of



nurses and midwives gain more recognition?

These are just a few of the questions that arise for us as these changes to health care are implemented. The following issues are just a small selection of the link between the current and future health service context and nursing and midwifery career structures.

The Structure and Infrastructure of Health Service Organisations:

Contemporary models of health service management need to be considered alongside the questions of nursing and midwifery structures. The 'Redesigning Care' model adopted by Flinders Medical Centre (FMC) is one such implementation of current management thinking in health care. The underlying theory here is termed 'Lean Thinking'. At FMC this is applied by following the patient journey (the 'value' added for the patient), highlighting duplication, delays and potential for errors, and then redesigning work processes and practices to improve the outcome for patients and staff.

The impact of organisational structure, and in particular, restructures, on nursing care delivery has also become an issue for consideration.

Recently, reviews have followed widespread and dramatic clinical quality failures in hospitals. In the Report of the Royal Melbourne Hospital Inquiry (2002), nursing profession issues emerged as being particularly affected by management and infrastructure issues such as rapid turnover, vacancy and instability of the Director of Nursing position and the dramatic reduction of nursing middle management positions (from 9 to 2 in three years) and nurse educator positions (reduced to 5).

In addition, the Report states that: "a continuing criticism is that Divisional structures have an isolating effect and

do not enable full advantage to be taken of collective knowledge and expertise, lead to unnecessary duplication of effort, and fail to present a shared view of organisational issues.

The sheer size of RMH causes problems in terms of a lack of continuity and coherence. Patients move across Divisions but Divisions tend to behave and operate as isolated units with the priority on economic management. This means patient-centred care is not central as it should be. Instead the focus tends to be on managing resources within a Division (2002).

Another hospital where the organisational structure impacted on standards was King Edward Memorial Hospital. "The Hospital's devolved management structure was meant to improve clinical decision-making and responsiveness to clinical care needs. However, unclear lines of authority, responsibility and lack of accountability for clinical care and decision-making resulted in poor staff and patient outcomes....Management failed to address problems with the devolved management structure, and failed to resolve long-standing clinical and management problems affecting the safety and quality of care" (ACSQHC 2002 p24).

A nursing/midwifery career structure needs to avoid compounding organisation structural problems linked to poor service standards, and needs to be flexible enough to provide support for improvements and modernisation in care delivery across a health service.

Accountability and Clinical Governance:

One feature which impacts on nursing and midwifery positions is the level of accountability ascribed to that position. Recent quality management work emphasises a systems approach rather than focusing on individual blame.

However, for systems to work effectively, all health professionals need to accept and act on the accountability required in their role. While financial, Occupational Health and Safety, and Human Resource accountabilities are widely understood and involve management processes to hold nurses accountable, the issue of clinical accountability appears less well developed, as demonstrated in the following examples.

Value Statement 5 in the Code of Ethics for Nurses in Australia states: "Nurses fulfil the accountability and responsibility inherent in their roles". Two of the explanatory comments attached to that statement indicate the expectation of clinical accountability.

"As morally autonomous professionals, nurses are accountable for their clinical decision making and have moral and legal obligations for the provision of safe and competent nursing care. (And) nurses have an ethical responsibility to report instances of unsafe and unethical practice" (ANMC 2002).

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

The NSW Patient Safety and Clinical Quality Program, includes accountability as one of six principles under which all clinicians should practice. In addition, this Program includes the principle of "obligation to act" which states "the obligation to take action to remedy problems is clearly accepted and the allocation of this responsibility is unambiguous and explicit" (NSW Health, 2005 p3).



Team Care:

Strict hierarchies are changing to multi-disciplinary teams - though some would suggest that the role of nurses in these teams is yet to be fully recognised. There is movement from jobs for life to careers for life through multiple jobs. Professionals are called on to be more flexible and may be required to work in a more project oriented manner, changing tasks across shorter periods of time. Workers are being asked to balance autonomous work with being part of a team (Bartlett, 2004).

Increasingly, (the) past individual (doctor) approach to treatment will be overtaken by the need for team approaches, underpinned by evidence and outcomes, clinical pathways, and guidelines.

Yellowlees believes there will be a need for fewer doctors beyond 2010. Not only will so much present-day medical content, knowledge and expertise be less important, but a group of highly skilled home healthcare professionals will exist. These healthcare providers will have prescribing and other treatment roles for patients being treated within pathway and guideline protocols (1999).

The Era of Knowledge Workers:

The term "knowledge worker" was coined by Peter Drucker some thirty years ago to describe someone who adds value by processing existing information to create new information which could be used to define and solve problems (Nagananda, 2000).

Nursing work covers a range from manual work to knowledge work – the balance being determined by the type of work context and the work role expectations. Registered nurses and midwives in particular undertake work that is more about problem solving than manual production, using

intellectual skills, using judgement and adding experiential knowledge to formal knowledge in "doing nursing".

As nurses and midwives are better recognised as knowledge workers, the community, professions, and organisations will recognise that the number, range and complexity of clinical decisions and liaison relationships as much constitute workload as the number of showers, wound dressings and medication administrations.

Work Role Redesign:

Stephen Duckett believes that "the focus on workforce flexibility is in part a response to perceived overspecialisation of the health workforce" (Duckett 2005). In Australia, specialisation is still developing, often narrowing areas related to specific conditions or treatment interventions and limiting work roles.

But Duckett believes specialisation is increasingly seen as "possibly detracting" from continuity and quality of care, and "is perceived to be inefficient either because more staff are employed than would be required in an efficient organisation of roles, or staff at higher pay classifications are being used to perform tasks which could be performed by staff at lower pay levels" (Duckett 2005).

The need to better utilise the skills of the current health workforce, exacerbated by shortages in many professional groups, is driving the concept of redesigning work roles to achieve greater flexibility, and to foster a more flexible adaptation of skills to different contexts of care delivery.

In the NHS, role redesign involves expanding the depth and breadth of roles, creating new jobs or moving tasks up or down a traditional uni-disciplinary ladder. Role redesign is changing traditional and long-standing barriers to change such as

professional boundaries, team structures and hierarchies, existing care processes and established divides between organisations" (NHS 2004).

It is unfortunate that the current discussion about role redesign has tended to generally describe change options as "role substitution". Such terminology is then used to encourage a view that changes will automatically infer less quality or skill.

Movement of tasks between health professionals has long been a feature of care delivery. Any nurse who rotates between weekday shifts and weekends or night shifts can provide a list of roles that are undertaken "after hours" in comparison to the hours when medical, allied health and clerical staff are more abundant.

The issue of role redesign is inherent in a redevelopment of a nursing and midwifery career structure, however these roles can no longer be considered in isolation from surrounding health professional and non clinical roles, or from changes to service delivery.

Over the next two years, this project will be keeping in touch with service delivery changes as they evolve in the South Australian health care domain and with work on matching employee skills to the new delivery models.

Where are Nursing Jobs Located?

Location	RN	EN
Capital city	82.6%	66.8%
Large rural centre	1.3%	1.2%
Small rural centre	4.9%	7.0%
Other rural area	10.0%	23.2%
Remote centre	-	
Other remote area	1.2%	1.8%

Source AIHW 2001



Statistics:

What did the latest data on nursing/midwifery workforce in SA look like?

Area of work	%	Average age	% male	% RN/RM	% EN	% Part Time
Medical, surgical, mixed	28.6	40.0	6.9	69.9	30.1	61.6
Aged care	13.6	46.5	4.6	57.5	42.5	56.9
Non clinical	11.6	45.1	10.9	84.2	15.8	39.2
Critical care	9.0	37.8	14.0	93.3	0.7	52.9
Peri-operative	6.6	41.5	7.0	83.8	16.2	56.9
Midwifery	5.6	42.8	1.2	98.3	1.7	73.3.0
Community Health	5.5	44.5	5.0	80.0	20.0	62.2
Mental Health	5.0	46.6	34.1	80.4	19.6	27.9
Family and Child Health	2.5	43.0	3.2	91.9	8.1	57.3
Rehabilitation/disability	2.4	44.8	19.6	53.0	47.0	51.7
Other	9.6	43.9	8.2	76.3	23.7	51.5
Overall	100.0	42.7	9.0	76.3	23.7	55.9

Source AIHW 2005

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