

# CAREER STRUCTURE – Survey: Proposals Paper

## QUESTIONS AND ANSWERS to 7 January 2007

**Please Note:** Answers given here are from the Principal Project Nurse and do not necessarily represent the views of the Department of Health.

### QUESTIONS AND ANSWERS - 29 December 2006 to 7 January 2007

#### 1. QUESTION: Some comments about “the A-H grade” have been raised and these are addressed here:

- **The proposed structure of A - H grade is not viable:** The use of the word “grade” occurs only in the diagram on page 2 of the Proposals Paper. The word ‘grade’ was only used to try to differentiate the two structures in the summary diagram. The proposed SA structure is NOT anything like the current or previous UK structures.
- **The A-H grade is no longer being used in the UK and comes with too much baggage of the highly hierarchical structure there:** As indicated above, the SA proposal has no relationship with structures currently or previously used in the UK. The proposals should be considered in the detail of the paper, and related to the individual changes proposed to the current structure.

On the issue of ‘hierarchy’, it would appear from many feedback comments through the Career Structure Review that hierarchies are alive and active in South Australian nursing and midwifery! There appears to be an issue about who is “top dog” in some workplaces, and who will or won’t take responsibility. Also, it seems clear that some wards/units operate with a “hidden” internal hierarchy – according to views about who is “senior” and who is “junior” among a group of RN/RMs. Good quality care, skills and ability are not necessarily directly linked to length of time in an area, any more than being directly linked to formal qualifications. The Career Structure proposals try to recognise that there are several components to developing and rewarding advanced and then expert nursing/midwifery skills.

- **Nurses from England spoke of stories where new grads got a higher grading than nurses who had been nursing for 10 years:** As the Paper indicates, such an outcome would not be possible in the SA proposals. There is no proposal to remove the current annual increment structure of Registered Nurses/Midwives with new graduates commencing at Level 1 Year 1 and progressing through annual increments, so that with 10 years of time worked, the nurse/midwife would be at the top increment of Level 1 (currently Year 9 and thereafter). Secondly, the proposal to increase the opportunity to progress more rapidly through Level 1 and then Level 2 annual increments is based on reclassification criteria that would include a minimum of three years experience. Thus in this proposal new graduates would not be eligible to apply for reclassification.
- **It appears the A-H grade is being looked at because it increases the scale downward not upward:** While the issue of actual dollar amounts is not part of the Career Structure Review – but will be addressed in the Enterprise Bargaining negotiations – there is nothing in the proposals that would underpin an argument to decrease any salaries. The proposals for “fully clinical” roles at Level 3 and Level 4 are specifically designed to provide more upward movement options without moving from clinical to management roles.
- **The A-H grade is not in alignment with other States:** See answer to Question 3 Dec 21 – Dec 29 (below).

#### 2. QUESTION: Why do we need to create so many different roles when we need nurses and midwives in the clinical areas? Can't we fix the shortage first? Can't we create more NP roles before trying to create such a diverse and difficult and expensive career structure?

**ANSWER:** There are actually few new roles proposed. One is the Advanced EN role and the other is a fully clinical role equivalent to the current Level 4 classification. The proposals at Level 1 and 2 have been made in response to feedback about what nurses and midwives think will improve retention and what will improve the attractiveness of career options and recruitment. At Level 3, all the roles mentioned in the Proposals Paper already exist (although not in all workplaces) but they are not as common as many nurses, midwives and health organisations would like.

There have been less than two dozen Nurse Practitioner roles developed in the last decade in SA. There is currently work underway in several health care services to develop more NP positions. This will continue simultaneously with the new Career Structure – each compliments the other process. Even with these extra positions – there needs to be improved career possibilities for a much larger percentage of the many thousands



of nurses and midwives in the State public sector. Nursing and midwifery are diverse and complex practice professions – it is difficult to balance this practice diversity with a relatively simple classification structure.

**3. QUESTION: I would like more detail on the level F/G/H please?**

**ANSWER:** There is more detailed work being done to develop criteria to distinguish these proposed levels. Levels F and G would replace the current A, B and C Banding in Level 3 roles.

**4. QUESTION: If it's not broken, there's nothing to fix! Why are we changing the current structure?**

**ANSWER:** There have been a small number of respondents during all the surveys whose view is that things should stay the same. However, overwhelmingly, the feedback has indicated a wide range of things that need to be "fixed" or changed or modernised. The proposals are an attempt to address as many of the major issues as possible. If you feel that there are no issues for change you may wish to read the feedback to Survey One: Context last question, which indicates the kinds of changes your peers are seeking.

**5. QUESTION: Why can't we concentrate on good quality patient care instead of who can do what?**

**ANSWER:** Hopefully we are doing both. The health service delivery evidence shows that some of the factors that contribute to good patient care include the way in which work is organised, having the most appropriately educated and experienced staff doing work appropriate to their abilities, and setting remuneration and conditions that attract and keep people of each generation in the workforce. Those are also goals of career structures.

**6. QUESTION: In relation to the Level 1 to 2 reclassification criteria:**

- **What are the mechanisms for ensuring the criteria are continually being met?** The proposed reclassification process occurs only once at a given point. The issue of nurses/midwives continuing to deliver good quality practice is not something you can ensure with a salary classification structure. Ongoing work performance is a matter for local management using performance management processes. Some may also believe it is our professional responsibility to address poor performance of our peers but this is usually a very challenging issue.
- **What if the nurse has multiple classifications in differing areas? Is one area viewed as the major area and other roles viewed as not as significant? Is this governed on time spent or importance of position, or location of employment?** An employee should be employed under a single classification – other arrangements may be in breach of industrial awards. If there are two separate employers, each situation is treated according to the classification under which the employee is employed.
- **Is this only for hospital based nurses? What of those in Occupational Health areas or private or community, or rural areas?** The proposals are for all public sector nurses and midwives – in hospitals, organisations, community, metropolitan and rural settings. Nurses and midwives employed by private organisations are employed under different Awards and Enterprise Agreements and are not included in the Review.

## QUESTIONS AND ANSWERS - 21 December to 29 December 2006

**1. QUESTION: Will nurses and midwives all have to reapply for their positions as happened in the previous career structure change?**

**ANSWER: No.** There will not be a "spill" of all positions as happened 20 years ago. If the proposed new structure is accepted, agreements about transitions to new roles will be part of what is negotiated in the Enterprise Bargaining (EB) process. For example: current ward/unit Clinical Nurse/Midwife Consultants (Level 3) would probably have the opportunity to decide between continuing in the operational management role (Clinical Service Co-ordinator) – that is running the ward/unit, or moving into the new clinical role (Nurse/Midwife Consultant) – that is, undertaking a clinical consultancy role attached to patients rather than organising a ward.

When such transitions to new structures occur (such as in organisational restructures), there is mostly a match between people and positions. However, usually where more than one person wishes to move into one position, then a selection process occurs.

Where additional new promotional positions occur as a result of the new career structure then standard selection process would apply.



**2. QUESTION: What is the difference between the F and G grades?**

**ANSWER:** There is more detailed work being done to develop criteria to distinguish between the proposed F and G grades. These two levels would replace the current A, B and C Banding in Level 3 roles.

**3. QUESTION: Why can't there be a national classification scale?**

**ANSWER:** There are many similarities but also many differences between the nursing/midwifery career positions in each of the States and Territories – or jurisdictions. The differences include different ways of organising health service organisations, different approaches of Health Departments and different industrial laws. In addition there are different approaches between State branches of Unions and different union coverage. Also, nurses and midwives in different States and Territories often have differing views on how nursing work is best organised. For example, Level 3 positions in South Australia try to divide management roles from clinical roles because SA nurses/midwives believe that management tasks continually overtake clinical care at promotional levels, and that putting all the roles together results in an unmanageable workload. In some other States, nurses/midwives believe that all parts of the promotional role – ward management, education and clinical care should be kept together in a single role.

It is unlikely that all these differences could be resolved in a way that would result in an agreed single structure for nurses and midwives across Australia.

**4. QUESTION: How do you define a level 3 role? How could staff attain Level 3 status? How would increased Level 3 positions be funded? How could you ensure adequate succession planning?**

**ANSWER:** The levels of nursing or midwifery work (such as Level 3) are largely defined by three processes: determining what types and levels of nursing/midwifery work a health service organisation needs, determining what would be attractive in a role in order to recruit and retain people to work in the role, and in industrial terms, determining the work value of a role. 'Work value' is an industrial concept – in some ways it is about what an organisation or health system will pay to get a certain amount and quality of work. It is not necessarily a community concept of value and is always about a role, not a judgement of a person in the role.

Nurses or midwives attain Level 3 roles by applying and being selected for them when they are advertised.

Funding for increased numbers of positions (and salary levels) is negotiated in the Enterprise Bargaining process. Since the State Government funds public sector nursing and midwifery positions, they determine the funding allocated to Health Units for nursing/midwifery positions and salaries.

Succession planning is one form of education and development. It is the responsibility of a Health Unit's management team to ensure such development of staff.

**5. QUESTION: Can you apply more than once for reclassification? Do those with Masters jump higher than those with Grad Dip?**

**ANSWER:** If you were unsuccessful in your reclassification you could apply again at a later date, however, once reclassified you remain that way and do not apply again.

The "jump" is made by achieving the reclassification criteria not by the level of qualification held.

The difference of financial reward for different levels of qualification is addressed in qualification allowances, not reclassification processes.

**6. QUESTION: A number of issues have been raised in relation to reclassification and these are addressed here.**

- **All areas need to be recognised and not just the academic side rewarded. Patient care is our first priority as nurses, not paper work:** Reclassification criteria proposals seek to balance demonstration of knowledge ('the academic side'), skills and a record of delivering good quality care. Good quality nursing and midwifery care include the ability to think, ask pertinent questions, analyse information, make decisions and use the brain as well as the hands. Good quality nursing and midwifery care also include the documentation required to maintain continuity and reduce communication errors that compromise patient safety. (One of the difficulties nursing and midwifery constantly face – among health professionals and the general community – is the idea that you just need to be a nice caring person and don't require a decent education. It is the balance of intelligence and relationship that exemplifies good nursing and midwifery).



- Some colleagues with twenty years experience and appropriate qualifications chose not to seek Nurse Specialist classifications because of the paperwork: If a nurse or midwife chooses not to apply for reclassification and increased pay that is of course the individual's choice. However, if a qualified and experienced nurse/midwife is not able to describe their work, how they make a difference, or their underlying approach to their profession, then this raises a need to seek education and support. If we as nurses/midwives can't articulate our professional work, we can't expect others to value and recognise it.
- I think it would be good for the reclassification process to be centralised, regulated by the Specific Nursing Colleges: Since reclassification is a payment issue, it is the role of employers and employee representatives, rather than a role for Professional Colleges.
- The jobs available for level 2 RNs in a specific organisation would always be limited by numbers. Extra level 2 roles would create difficulty running a unit (too many people trying to do the same thing). Concerned about the limitation of current RN level 2s to work during office hours: These concerns make certain assumptions that are based on the way things work at present, rather than what is in the Proposals Paper. It is not proposed that the new concept of level 2 roles will be the same "associate ward leader" roles that are the main current level 2 hospital roles. It is proposed that "advanced" clinicians will be classified at level 2. Some of these roles will be "associate ward leaders" but many will not. All these roles will be expected to provide high quality care and to support less experienced staff. Options for undertaking additional functions are described in the Proposals Paper. It's not proposed that the new advanced clinician role be limited to low numbers per area or limited to "office hours" as is now often the case.
- Undermines the current Level 2: This concern is linked to those in the previous section. Most current Level 2s were appointed to and work in an "associate leadership role" or an 'advanced practice' role (particularly in community). These roles will continue. However, the work of these roles may be shared more evenly by having additional numbers in such roles. Also, it is likely that it will be current Level 2s who will most benefit from additional roles proposed at Level 3 – especially those focusing on expert clinical care and consultancy linked to patient groups rather than organisational work areas.
- There is a difficulty in a centralised panel understanding the different needs of the different health units. Reclassification needs to be discussed and negotiated with line manager based on the work needs and proposed role within the organisation. Other bodies could make recommendations for the role or position, but those working in that immediate environment should have the final say: While reclassifying a particular role or position to a higher classification level is usually a local issue and related to the organisation's needs, the reclassification of a nurse/midwife in the Level 1 range to a higher pay rate is not the same. The proposal to centralise the salary level reclassification process aims to develop fairer and more consistent processes than have occurred in the past.
- May not necessarily get the best person for the job, just because you meet the criteria and want the job doesn't mean suitability: Being selected for a position should involve meeting and demonstrating selection criteria requirements - which should include those criteria that indicate suitability of the person for the position. Reclassification of a salary level may require meeting certain criteria but is not the same as being selected for a new position. If a person performs poorly in a certain position (including failing to demonstrate suitable knowledge, skills and attitudes – i.e. competencies) that is a performance management issue.
- Expectations of new graduates that they "should" be in the role even though they have limited experience: The criteria proposed for reclassification could not be met by a new graduate. The combination of the experience and additional (to entry level) knowledge proposed would not be attainable by a new graduate.

## QUESTIONS AND ANSWERS to 21 December 2006

### 1. QUESTION: Please clarify if the Advanced Diploma in Enrolled Nursing is the equivalent of the Diploma Enrolled Nurse as at present, or is extra study needed?

**ANSWER:** No these two qualifications are not equivalent. The Diploma is the current entry qualification for ENs. The reason a lot of already qualified ENs are doing the Diploma (a shortened post enrolment version that gives credit for experience), is to **update** their qualifications. This process in itself does not change their role.

Remember when the RN entry qualification became a degree? When that occurred, many RNs upgraded their qualifications to the degree – this did not change their role.



The Advanced Diploma in Enrolled Nursing is a 'post graduate' course for ENs. You have to have a Diploma or equivalent before you can enter it. This qualification is not yet available but is in the final stages of national accreditation and will be available in 2007.

**2. QUESTION: At present one our ENs who has completed his Advanced Diploma will not administer medications that they are being paid to do?**

**ANSWER:** This EN is more likely to have completed a post enrolment Diploma – not an Advanced Diploma (see Question 1). There are two issues in your question. One is about the EN undertaking work assigned to him. Unless the RN's request is illegal or managerially unreasonable, the EN who has undertaken medication units of study has no grounds to refuse to administer medications. Refusing to do assigned work should be dealt with by performance management by the EN's supervisor.

The second issue is about ENs and medication administration. For some reason, some RNs have made this into an issue way beyond its importance. Except for less common issues such as administration by intrathecal, intrathoracic etc avenues, dosage titration and emergency medications, administration of standard medications can be undertaken by many types of health workers and others. The greater issues are clinical assessment and decision making – decisions about withholding medication, having prescribed amounts reviewed and evaluating the successful or otherwise impact of medications. These skills are not in any EN course and are clearly RN roles and not EN roles. Administration is mainly a technical or manual skill, but the assessment, evaluation and decision making are cognitive skills – skills of thinking and judgement.

**3. QUESTION: Will there be blurred lines between RN and EN? Is legal clarification required?**

**ANSWER:** It is hoped that formalising an Advanced EN role will decrease the current blurring that occurs when ENs are given different ranges of delegations without agreed criteria. Legally, ENs can undertake any nursing activity delegated to them by an RN, as long as they have been appropriately educated in the competencies of the activity. The only exceptions would be being asked to do something illegal, unethical or unprofessional (ENs are accountable for their own actions and if they act in an illegal or unprofessional manner, this is fully their responsibility).

**4. QUESTION: What will happen to nurse specialists?**

**ANSWER:** The classification of 'nurse specialist' would no longer exist. This classification was introduced to try to better reward advanced clinical practice – however, for a range of reasons, it was generally viewed as not successfully achieving that outcome. In the proposals, there are alternative methods that would reward that advancement in practice for Level 1.

**5. QUESTION: How do these proposals compare with what is happening Australia wide? Does this bring us equality with other States or leave us lagging behind?**

**ANSWER:** It is extremely difficult to compare career structures in different jurisdictions (States and Territories). It is also hard to compare public and private sector structures. Each career structure is developed in accordance with the context in which the nurses and midwives are working, and the local industrial requirements. In January an article outlining some of the roles found in other States and countries will appear on the website.

The equality referred to in the question is most likely about wages and conditions. These will be negotiated during EB (see questions above). Further information on relative wages between States can be obtained from ANF or DAIS websites.

**6. QUESTION: Do you believe that acute ward CNCs should be paid at a higher level than a designated CNC or a Level 3 with no staff under their supervision?**

**ANSWER:** There have been several suggestions in the Review feedback about which roles should be paid more than others. The industrial decisions about what places a role at a particular classification level are based on what is called 'work value'. Work can be very different in nature but may be regarded as of equal work value in an industrial sense. Work value is based on a role, not the person in the role.

The Review proposals are trying to move away from a management driven nursing/midwifery career structure to one that gives more value to clinical roles. To pay a Level 3 role more because they manage staff when another



Level 3 role has no staff but provides expert clinical care would reinforce the view that management is of more value than nursing/midwifery.

**7. QUESTION: All I really want to know is in regards to Level 1 RNs – will a first year RN get paid the same as a nurse who has been working for 9 years?**

**ANSWER:** No. Have another look at the diagram on page 3 of the Proposals Paper. It shows that it is proposed that the current 9 annual increments would remain as a form of 'progression' in Level 1. The proposed changes relate to using reclassification to give nurses who choose and achieve reclassification (via meeting defined criteria) an alternative form of progression.

**8. QUESTION: Is there going to be a limit to how many Level 2 RNs there will be in one establishment? Is there going to be adequate remuneration? If so, where will the money come from?**

**ANSWER:** It is proposed that there be NO limit to the numbers in the Level 2 classification, although the role will be different to the current concept of a Level 2. However the issue of whether the numbers are unlimited will be negotiated during Enterprise Bargaining (EB) between the ANF and the SA Government. Levels of remuneration will also be part of EB negotiations. The EB process is where our regular wage increases come from. In terms of the funding for EB outcomes – this is largely funded by the Government through additional budget monies to health services, as for medical staff, medical consultants, allied health professionals and administrative staff pay increases.

**9. QUESTION: What about 24 hour 7 day a week coverage for current Level 3s built into the role?**

**ANSWER:** It is proposed that the decision about whether particular Level 3 roles cover a 7 day roster rather than a 5 day roster should be made on the basis of the need for the role in the service environment, rather than being restricted as a cost cutting process. The proposals support the availability of expert and advanced clinicians across days and shifts according to patient need, and the need to support less experienced clinicians.

**10. QUESTION: Will there be a Nurse Practitioner Candidate level? What about Nurse Consultant level? Why are Nurse Practitioners the only role that will have to negotiate their level?**

**ANSWER:** It is not proposed to have a separate level for those individuals who are in the process of seeking Nurse Practitioner (NP) authorisation. The proposals assume that such nurses would be in the new Level 2 roles or Level 3 fully clinical roles as described in the Discussion Paper. In academic circles the title candidate appears to mean a student seeking a particular qualification – such as doctoral candidate. In the health sector, nurses are employed in roles that they are equipped for, and then develop additional skills in order to apply for higher classification roles.

It is not proposed that NPs will have to negotiate their level. There is further work occurring to clarify the work value differences between clinical roles in the "F, G and H grades" in the proposed structure (see page 2 of Paper). Included in that discussion will be the work elements included in Nurse Practitioner roles. While the NP role has to date been considered by many to be the highest clinical classification achievable, it is just this lack of high level classifications for clinical expert roles that the Career Structure proposals are seeking to change. Some of these clinical expert roles may include extended activities (that is, activities that traditionally have not been done – or acknowledged as being done – by nurses), and some may not. Some of these roles may need to be filled by NPs and some may not. The Career Structure has to allow for multiple options to address different needs in different settings.

**THANKS FOR PARTICIPATING...**  
**Watch for further questions and answers**