

CAREER STRUCTURE – Survey Three: Acute Work and Roles Feedback as of 8 December 2006

270 people have accessed the survey and 162 people have completed it.

Roles classification	
EN	7%
RN 1 or 2	27%
RM 1 or 2	7%
RMHN 1 or 2	3%
Level 3 and above	53%
Other	3%

Main type of work	
Clinical practice - general	45%
Clinical practice –midwifery	9%
Clinical practice – mental health	8%
Management/Administration	29%
Education/Research	8%
Student	1%

Work location	
Country	22%
Regional city	9%
Metropolitan	69%

Work setting	
Hospital	93%
Community	7%

Generation	
Matures	2%
Baby Boomers	75%
Generation X	20%
Millenials	3%

What activities if any, that are currently undertaken by doctors do you think could/should be undertaken by registered nurses?

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

- Cannulation, blood samples, naso-gastric: insertion of tubes.
- Cannula insertion, referrals.
- IV Cannulation, commencement of IV therapy, prescription of minor drugs ie paracetamol, etc.
- Cannulation, male catheterisation, delivery of newborns (Reg Midwives).
- Prescription of medications, administering the Mental Health Act (eg detention and reviews), requesting of investigations, referral to specialists, birth interventions (eg forceps etc).
- Many tasks that occur in A&E and special care areas.
- Inserting PICC lines, Consenting patients for contrast injection in CT.
- IV cannulation.
- Mental health brief assessments, emergency mental health assessment, short term detention for MH assessment, initiating admission to local country hospitals & initiating medication as per prescribed protocols.
- Dressing prescriptions, insertion male catheter, intravenous cannula insertion.
- Insertion of IV cannulas, Insertion of IDC, prescribing of IV fluids.
- Providing RN has the appropriate knowledge and education cannulation, dressings care and dressing choice decisions, primary health care.
- Jelco's, routine bloods(pt's fast til 10am for 1 blood sister to come through the whole ward) , male catheters with no prostate problems, naso gastric drainage tubes, Peter Mac (Melb) nurses insert naso gastric feeding tubes- they get xrayed before use. Ordering of urine MSSU's when ward U/A's are positive, referrals to Acute pain, chronic pain, DARU.
- Some Lab tests routine x-rays for fractures.

Responses from 20 July 2006 to 14 August

- X-rays, male catheterisation, suturing, removal of lesions, biopsies, PV's, IUD's,
- Monitoring patients with chronic disease & co-ordinating their management.
- IV cannulation, male catheterisation, admission of patients, pre-admission assessment, referral for tests & X-rays. Suturing, plastering. Referral to other disciplines. Routine procedures (ie Sedationist role), colonoscopy, endoscopy etc. Initiating restraint orders.
- Wound management, prescribing certain medications ie like nurse initiated meds. Requesting some pathology etc.
- Arterial blood sampling, arterial line / PICC line insertion, NG insertion, Male catheterisation, most of these procedures end up being undertaken by interns who have had limited experience and or exposure to the procedure.
- Jelco insertion, ordering of routine blood tests and x-rays which are standard and common practice within our unit, development of protocols such as nurse initiated analgesia protocols.
- Referrals to services/ specialists; signing sick certificates; giving results.
- Referrals to specialists/services; assessments.



- Cannula insertion.
- Decisions regarding a person being transferred into community.

Responses from 15 May 2006 to 20 July 2006

- Insertion of IV's, etc. suturing, plastering.
- Regular blood tests - eg INR. In house referrals
- In country MH admissions to metro hospitals - usually the MHN knows more than the GP about the system and what is a suitable admission or not. Ordering standard bloods for physical workup to rule out physical causes for Mental Illnesses. Sick certificates for client workplaces.
- Initial detention orders limited prescribing rights ordering of basic investigations
- Discharge planning.
- Prescribing medication and ordering pathology. In mental health initial detention for treatment under the Mental Health Act.
- IV cannulation management.
- We already have an underlying role in providing young inexperienced doctors with information in patient management. i.e. fluid management, analgesia requirements and reporting particularly in peri-operative areas where clinical skills and experience are specialised.
- Basic health checks, mental health assessments.
- Videoconferencing.
- IV Cannulation, ECG monitoring, routine tracheostomy changes.
- Prescribing (some) medications, invasive line insertions (peripheral IV, nasogastric) ordering investigations (Xrays, blood assays).
- Referrals to some specialists/allied health eg. home medication reviews by pharmacists, radiology/pathology. Extension of wound/ emergent care eg suturing, prescribing analgesics and antibiotics. Admitting rights to ward beds.
- Assessment of patients; ordering of routine tests (bloods, radiology, etc).
- ordering mild pain killers, aperients; insertion of N/E tubes with rights to order check X/Ray for position then doctor can review the x-ray from computer anywhere. Write up new drug charts if no changes have occurred. Routine tests ie CXR, IDC's on all pts. Referrals from senior RNs to other clinics without that old fashioned "it must come from the doctor". (IV insertion, blood extraction, some already do) Mind you we do enough now and too many tasks may only make you mediocre at a lot of things.
- Standard test ordering, IV insertion, NGT insertion, PICC insertion.
- PICC line insertion. Nasogastric insertion in adults. Male Catheterisation. Straight forward Angiogram, not a angioplasty or angiostenting, just the angiogram.
- Bowel management.
- Clinic follow-up, exercise stress test, blood forms.
- IV cannulation, and for doctors to work more in a team environment valuing nurses assessment skills.
- Nurses are already doing many tasks that traditionally were medical work, such as, IV cannulation, pt assessment, D/C planning, D/C letter writing, co-ordination of follow-up care, wound management. There isn't a lot more that could be undertaken except by nurse practitioners.
- A number of diagnostic, investigative and treatments currently done in the acute care setting can be undertaken by nurses. Examples of these are Hormone implants, lumbar punctures. muscle biopsies, abdominal/plural taps.
- IV cannulation, endotracheal intubation in appropriate circumstances, greater flexibility in ordering Xrays and some other tests, greater range of nurse initiated medications/wider use of drug standing orders. Basic suturing of simple wounds, male urinary catheterisation, health assessments of some patient groups such as those having functional capacity assessments through rehabilitation providers like CRS.
- Physical assessment & then present findings to assist in reaching a diagnosis. Bloods. Commencing specified group of simple meds -IV cannulation -insertion of NGT/IDC -gastric lavage -suturing (most of these already carried out in some areas i.e. ED but could be rolled out formally).
- Insertion of IVs, etc. suturing, plastering.
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- We already have an underlying role in providing young inexperienced doctors with information in patient management. i.e. fluid management, analgesia requirements and reporting ,particularly in peri-operative areas where clinical skills and experience are specialised.
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- Videoconferencing.
- IV Cannulation, ECG monitoring, routine tracheostomy changes.
- Prescribing (some) medications invasive line insertions (peripheral IV, nasogastric) ordering investigations (Xrays, blood assays).
- Assessment of patients; ordering of routine tests (bloods, radiology, etc).
- Nurses can undertake many tasks performed by doctors within specific focused areas if they have had specialised education to undertake these activities and have been credentialed or authorised to undertake them.
- Preoperative nursing assessment.
- Suturing, medications (have standing orders, similar to the prison health service).
- Within my scope of practice the writing of treatment orders.
- Nurses in specialist fields could be consulted, eg diabetic nurse. Adolescent nurse specialist could be consulted in relation to adolescent behaviour and to assist in patient compliance etc. Undertake minor invasive procedures eg insertion of a jelco.

Responses up to 15 May 2006

- IV cannulation, blood sampling, ECG, ordering of tests, naso-gastric tube insertions, catheter insertions male, arterial blood gases, order chest X Rays;
- Cannulation, patient assessments in A&E, ordering patients' usual meds, ordering x-rays etc after discussion with MO, ordering routine blood tests, eg pre-op. Any treatment order that is obvious and routine.
- Surgical Assistant roles intra-operatively: Peri-operative Nurse Practitioner role: Scopes & pre & post op care;
- Not so much activities but if doctors were able to work within a more team orientated environment valuing the skills that nurses have to offer and treating them as equal partners along with the client it would ensure better quality care to clients;
- Some of these activities are shared, however the amount varies. IV Jelco insertions, Nurse initiated patient discharges, Nursing clinics, Referrals to allied health workers. Decision making re treatments eg. type of dressing, Nurse assessment of emergency patient presentations, Nurse prescriptions.
- IV insertion, Male IDC insertion, ordering of X Rays and medications supported by protocols, Patient assessment in the ED or after hours to initiate treatments, nurse initiated discharge from hospital again supported by protocols;
- Ordering IV fluids and some drugs. Using ward clerks to book tests. Some method to reduce paper work in ordering tests. Nurse led ward round at designated times for all disciplines. Discharge drugs so they are done in time;
- Increased breadth and depth of client assessment - then triaging as appropriate For example a practice nurse screening certain clients before visiting the GP. Ordering of routine investigations Limited prescribing rights within an area of expertise - with pathways or protocols in place, For example a nurse with expertise in epilepsy could manipulate and change medications within agreed parameters Certain technical skills For example - cannulation, PICC-line insertion, routine suturing - depending on area of expertise. Limited admission rights where appropriate. Case management - nurses do this better than doctors anyway. Liaison work in area of expertise within one or more organisations. All of these things to be undertaken as part of an interdisciplinary team where role overlap is acceptable but there are well defined protocols/ policies and the support of all team members. The nurse does not replace the doctor but both work in a mutually supportive manner;
- IV insertion, suturing (however this is difficult in our setting due to minimal staffing), discharge summaries, triaging is happening more.
- Once diagnosed and following a plan of care, nurses could undertake the ongoing management of many conditions. e.g. diabetes, COPD, Hypertension and many more. Nurses would in fact manage some of these better because they would focus more on weight control, exercise - non medication interventions. Management of Wounds. Care of the dying. Many of the presentations at A. & E., e.g. suturing;
- Pre - op assessment, cannulation, limited nurse prescribing, ordering some investigations, In the UK, I have seen all these done very well, in many cases much better than the docs ever did them;
- Venepuncture (except Paeds), routine prescribing for Schedule 2 & 4 medications;
- Nil. This question should take into account the varied practice of some nurses. In the country some nurses suture. In my practice I do as much as I would like in the grey areas between MO's and nurses;
- Community mental health nurses are already doing clinical case management and doctors are brought in as needed;
- After conferring with MO requesting for blood tests, x-rays and change of medications[of which we can do on stat orders which can be signed & verified]Quite often changes can't be made till MO writes the order.



- There are certain tasks that could be completed by a RN/RM that are currently in the city being completed by a doctor. I know in the country however the RN/RM may be better utilised than in the city. For Eg. Inserting LMA, IV, Arterial Stabs for blood gases. In some areas there is a lot of tasks that a RN can complete instead of medical staff ie CCU/ICU where there is a lot of post grad training, where other areas would not cope with taking on more responsibility. The critical thinking is individual to the nurse and how experienced they are. So the decision making sometimes could be very gray
- Some ordering of blood tests as per guidelines. Pre-operative medication advice
- IV Cannulation simple pathology test requests eg MSSU, wound swabs, simple XRays
- It depends on the setting. As a level 3 in an extended practice role there is probably quite a lot I can do. Same can not be said for all nurses, however: some patient assessment, ordering bloods for routine conditions, ordering XR's, planning OPD's, IVT, some referrals (allied health & otherwise).
- Reviews of some patients in outpatients.
- Ordering of routine drugs eg standard use vitamins once already ordered once. Discharge checks Pathology requests for routine screenings
- Many things are now being done by nurses in an unofficial capacity - suturing, skin biopsy, CVC, PICC and peripheral catheter insertions, plastering of fractures, giving of any drug, anaesthetic procedures, then there are some being discussed such as lumbar puncture, muscle biopsy, etc.
- I believe that with the right circumstances these are many and varied. So much would depend on the willingness of the parties involved to either let go of or pick up activities.
- Ordering & administration of designated medications (prescribing rights) Ordering tests, x rays relevant to the patients condition & nurses educational/skill level Consulting with patients and assessing their needs from a pre operative perspective Referral to Dr's when/if required Assisting with surgery, suturing, management soft tissue injuries, plastering, referral, whole case follow through, prescribing simple analgesia, meds etc, test interpretation;
- I would hope that recognition of the role of the midwife: can functionally manage most antenatal, intrapartum and all postnatal care. Hence free up Doctors to manage those situations that require obstetric care and act in partnership with midwife/ Doctor. for those women needing high risk care.
- Ordering x rays and blood tests.
- Registered midwives should be able to prescribe and order drugs needed for routine management of pregnant women and should take responsibility for the care of normal healthy pregnant woman throughout the continuum.
- Ordering simple specimen collections.
- Wound care, compression bandaging, patient education individual and group settings / nurse led clinics; heart failure, chronic disease management, IV cannulation, facilitate family forum/case management. But tasks are not the main things, its the clinical reasoning / assessment which goes on continually which changes pt outcomes depending on expertise of nurse - referral, pathology testing. Prescribing of drugs within limited formulary: ringing up MO for analgesia, bowel problems, sleepers is often a time waster.
- At the moment we do more of there work than they do.
- I think we need to be cautious about taking on other's roles. Some areas still do not take blood, do ECGs etc, so perhaps this could be a focus at which to begin.
- Reinsertion of naso-gastric tubes, insertion of male indwelling catheters.
- Discharge check of newborns. Ordering blood tests, eg if baby looks jaundice, can do a blood test to determine bilirubin level. Discharge check of postnatal mothers.
- Initial detention of mental health clients.

If a nurse undertakes activities that have traditionally been undertaken by doctors and/or allied health practitioners, does this make the nurse better or more skilled, or is skill in nursing more than the range of tasks a nurse can do?

Yes, the nurse will be more skilled	13%
No, the nurse will not necessarily be more skilled	2%
Yes, the nurse will be a better nurse	1%
No, the nurse will not necessarily be a better nurse	3%
Skilful nursing is more than additional tasks	74%
Unsure	7%



What activities if any, that are currently undertaken by allied health professionals do you think could/should be undertaken by nurses?

CURRENT RESPONSES - 20 July 2006 – 8 December 2006 (See below for previous responses)

- Allied health professional have specialised in their fields, and have the expertise. Nurses are available 24 hours a day and are expected to undertake so many different roles. We could all assist each others roles but not be on the bottom of the scale and be expected to assist in menial tasks.
- None - because I believe that the allied health professionals have a skill of their speciality eg podiatry, physio etc.
- Basic mobility assessment, Aged care assessment.
- The roles of allied health professionals have eroded a lot of the role of nurses in the past. It seems that some professions are growing their roles (for example physiotherapists doing wound care. I feel strongly that we need to decide what nursing is about and not stand back and let others encroach what are important parts of nursing. Nurses should be involved in mobility and functional assessments and making clinical decisions based on these. Similarly dietary requirements could be initiated by the nurse with review by the dietician rather than waiting days for review and patient misses their dietary requirements. Tracheostomy care should remain in the domain of the nurse and not in control of the Speech Therapist.
- Midwives must be involved in any antenatal education and any early postnatal groups.
- Many of the tasks associated with allied health professionals are still today undertaken by nurses as we seem to be the fall back for 24/7 support of the Social workers, physiotherapists, dieticians etc.
- Assessment of social and family setting; education.
- Lots of the activities that are undertaken used to be performed by nurses. In the country regions due to lack of allied health professional staff many of these activities are still carried out by nurses.
- Basic patient assessment eg. swallowing and diet, ambulating ability.
- XRays, Ultrasound (Therapy).
- Living skills assessments'.
- Case management of patients to increase efficiency by having the right doctor for the right procedure at the same time.
- Nursing over past 15 years has seen other professionals undertake nursing roles as nursing role has been diminished, now OT, physios, social workers undertake the roles that I used to do as my skills have been restricted by employers. Just bring back what we used to do.
- Discharge planning is better when performed by nurses rather than social workers. Some physios could work more closely with nursing staff to facilitate better patient care/rehab.
- ACAT assessments.
- Physical therapy.
- Primary health care and education.
- Discharge planning and social work overlap.
- Some physiotherapy tasks that have now become solely physio ie postural drainage.

15 May 2006 to 20 July 2006

- A number of activities that nurses undertake are also done by allied health, nursing activities cover a lot of other professions activities, doctors included.
- Assessment of swallow reflex. Assessment of ADL's. Prescription of aids. Assessment of psychosocial status.
- None, nurses have enough to do now as it is.
- Chest physio -plastering/splinting.
- Swallow with Speechies but we need training back. Pts deteriorate usually out of hours and nurses need the skills to recognise what to do to keep pt. safe SA MUST NOT follow the path of other states and allow speech/physio dictate when trache cuffs are deflated or tubes removed. This is nursing 24/7!!! They can come in later for speech issues.
- Chest physio -plastering/splinting.
- I don't think it should be either or - it is working more holistically with all health professionals - it is the division of jobs that makes the continuum of treatment and care of patients disjointed and erratic.
- There is nothing that allied health do in MH that MHNs don't do.
- Assessment and treatment of clients in the community.
- Liaison with community teams referrals to metro home link and other agencies.
- Chest physio.
- Counselling.
- Counselling, liaising with communities to develop networks of support.
- Physiotherapy.



- Assessment of the patient.
- I think nurses should undertake some of the simple functions of allied health staff and refer on for complicated issues ie: often when a patient is admitted to an acute ward there is a request for OT assessment for additional services without any assessment being made of the patients current level of services and how they have been coping. Nurses have potentially been deskilling themselves by referring out in order to cope with workloads.
- Social work issues and counselling.
- Not applicable to my scope of practice.
- Allied health professional have specialised in their fields, and have the expertise. Nurses are available 24 hours a day and are expected to undertake so many different roles. We could all assist each others roles but not be on the bottom of the scale and be expected to assist in menial tasks.

Responses up to 15 May 2006

- Swallow reflex. Some physio tasks eg deep breathing and coughing exercises. Mobility assessments Many every day activities;
- I see it more about using each other skills and working within a collaborative manner to the benefit of the client.
- Assessment of patient swallowing and subsequent diet planning. Ambulation of post op joint replacements. Many activities undertaken by A/H staff are by default undertaken by nurses after hours.
- More physio interventions, home assessments, discharge planning, ACAT assessments, counselling.
- Currently we do the physios work and the OTs work. We help the pharmacist too. We are social workers and psychiatrists!
- As allied health only work part of any day, nurses already do allied health roles after hours, eg physio, social work and speech pathology.
- Assessment to have certain equipment. For example - there is often duplication in effort between roles and environments. The nurse assesses that the client will need a frame to go home - when the client goes home they may well be reassessed by Dom Care as they do not trust a nurse to assess that the client needs this equipment - there is often a consequent delay in issuing the equipment! There are many such examples.
- We have for years acted as diabetic educators, dieticians, podiatrists, physios.
- Mobilising persons following THR, TKR. Assessment of swallowing.
- Depends on the area really - the danger is in assuming all nurses in all areas are equal. For example, a nurse in a stroke rehab unit could easily be skilled enough to undertake a speech and swallowing assessment, but I wouldn't.
- Believe in a partnership approach to patient care.
- None, we work collaboratively and provide different dimensions of expertise that enables patients to return home safely.
- In community mental health nurses do most of the things allied health does and then specific nursing activities as well.
- Basic chest physio for eg. may be able to be completed by a nurse but I think in some areas they still require access to more knowledgeable specialists. Social worker and Transitional Care seem to overlap a lot and nurses tend to know the patient more, this is a questionable area. As for the rest of allied health I think they play a valuable part in the team and I really don't think we have the staff or the time to complete any of their tasks or roles.
- Home assessments, (OT), chest physio, exercises, counselling.
- A lot we do anyway but we don't always have the time ... someone has got to empty the pan and that should be us. Nutritional screening, counselling & advanced D/C planning, some advanced mobilising of patients, chest physio.
- Monitoring of routine bloods, and observations ie BP checks for hypertension.
- They all are after hours, except some crazy things like ordering the right consistency of fluid for a stroke patient with swallowing difficulties - kitchen won't accept any other order but a SP, but generally, nurses do all their jobs after hours.
- Nurses frequently undertake 'allied health' activities such as physio etc out of hours and on weekends - perhaps the question should be 'should this service be provided by allied health across the full week and out of hours?' rather than nurses undertaking allied health roles.
- Physiotherapy, nutrition, social work However, there should be the ability to refer on if needed.
- Some physio tasks to allow for coordination of care for pt. this allows rest periods rather than continual disturbance by numerous allied health professionals.
- Babies blood tests.
- Some speech pathology as in swallow testing.
- Teaching pelvic floor exercises discharges of postnatal mothers and their infants.



What activities, if any, that are currently undertaken by nurses do you think could/should be undertaken by allied health professionals?

CURRENT RESPONSES - 20 July 2006 to 8 December 2006 (See below for previous responses)

- None.
- Counselling.
- Nurses are able to fulfil the allied health roles after hours and on weekends. The usual role of allied health staff should be continued into these hours. It just puts an additional load and takes away from nursing. It confuses what is nursing.
- Counselling especially after hours in small rural communities.
- I would like to see these allied health professions adopt a client centred approach and be available for more extended hours over all days of the week. Just try and get a sandwich for a patient out of hours.
- Nurses can do parts of allied health tasks but allied health can't do nursing part of care.
- Depends on how much time the allied health professionals are going to spend on the wards, many of the activities require time that they do not historically spend with patients.
- Nurses are expected to 'carry on' with the work that allied health commence ie physio's asking nurses to walk with patients every shift when there is often not enough time to accommodate this.
- Running ward rounds, Occupational activities;
- Assisted walking, physio on weekend;
- Some human resource activities.
- More physios available would be good.
- All clerical duties ie admitting of patients and filling out of paper work and the ensuring that forms are signed etc. Believe nurses should be spending time getting good health histories and doing thorough patient assessment rather than stocking of supplies, shifting of patients from different areas of hospital.
- Transitional care etc.

15 May 2006 to 20 July 2006

- If speech therapists are determining consistency of diet, then they feed the pt. the entire meal while on duty. More social work /counselling intervention by SW.
- None x 4 responses
- Clerical duties, data entry, rosters, annual leave applications etc.
- Vital signs observation and recording -showering -supervision and/or assistance with exercises, activities as prescribed, feeding, dressing, mobility.
- Administration/ward clerk duties.
- NOCC/HONOS.
- Unsure, need their roles more defined.
- Mental state assessments.
- Referrals to community supports are often left to nurses to sort out after a allied health intervention and recommendations. Better access to Weekend Physios for acute respiratory patients would assist nurses to focus other areas of care.
- Patient interventions-treatments over the course of the 24 hour day including weekends. It is an insult that they expect us to carry out their instructions after hours and on weekends when they are not here, but expect us to stand aside when they are here (ie during 'office hours').
- There are many activities that AH could undertake, it just gets down to costs, workloads etc.
- None really in the clinical setting but in administration they could.
- Allied health professionals should offer their service 24 hrs a day. Doctors and nurses are available 24 hrs a day. I do know that some allied health professionals are on call..

Responses up to 15 May 2006

- Patient assessment for placement;
- We need more allied health and support. eg physio, OT, counsellor etc, plus ward clerks and ward assistants to do up dirty linen and restock.
- If there was greater cover then some aspects of placements and after hours care following discharge could be relegated to allied health allowing the nurse to do skilled nursing work.
- I think nurses have allowed their role to be eroded over the years - there are obviously areas of expertise however the client care is likely to become fragmented with so many 'experts' delivering different aspects of care. Team work is so important but many nurses fail to work in a team manner and abdicate their responsibilities to others. When it comes to the unsocial hours all of a sudden these activities are done by nurses. If we had access to allied health staff they could do their work.

- Feeding - dieticians/speech pathologists.
- None really that are not already done by them.
- Coding, organisation of case notes ie. retrieving or filing results.
- I think at the moment we could do with more allied health just as much as we need more nurses. Nurses in some hospitals do most of the rehab of patients. Whether they are guided well by allied health is a question to be raised. In my institution we have a great team, and they work as a team.
- Some personal hygiene (can be used as part of OT/physio assessment), Pressure area care.
- Cleaning of beds, restocking of areas, checking to see if things working ie oxygen and suction etc. Day surgery, someone to make patients tea and coffee etc
- A lot more related to social issues, placement issues, more mobilisation.
- Stores - checking & ordering of supplies.
- Would be reluctant to label any care that assists my patient in management of or return to health/illness issues as not nursing responsibilities.
- Bed and room cleaning on discharge so that nurses have more time to spend with patients.
- More social work and psychiatric support.
- It's fairly right where I work.
- Menus.
- None or no activities x 10 responses.
- Starting discharge letters. delivery of flowers, answering phone, stripping beds.

What activities, if any that are currently undertaken by registered and enrolled nurses do you think could/should be undertaken by assistants in nursing?

CURRENT RESPONSES - 20 July to 8 December 2006 (See below for previous responses)

- To provide holistic individualised care, the nurse allocated the patient care can deliver the best possible care. Tasks that the assistants in nursing could undertake would prevent the development of the professional relationship which is conducive to wellness.
- Personal Care - showering/toileting, Bed Making, Cleaning beds etc. Feeding patients.
- Basic hygiene needs. Bed making. Pressure Ulcer prevention, Cleaning (beds, equipment etc), Feeding or assisting patients to eat.
- Hygiene care, hotel services, taking observations, ensuring that meals/fluids are accessible to patients, assisting with meals, assisting with mobility, pressure area care. Talking with patients. Minding patients that may need a companion (ie intellectual disability, dementia).
- Bed making. Collecting long stay patient clothing for washing and putting away. Cleaning pan room etc.
- I would like to see support for the non nursing duties that I undertake eg answering the phone, finding equipment, locating drugs, cleaning bed areas, etc to allow me the time to focus my attention on providing the best quality care for my patients. Again ward clerks, allied health professionals, stores, cleaners, wards men working extended hours over a 7 day roster would reduce the need for nurses become all of these roles after 5pm.
- Cleaning of patient bays, stocking of clinical areas.
- Bed cleaning.
- Showering and other ADL's for patients could be undertaken by care workers. Vital signs.
- ADL's and bed making.
- None. Nursing assistants are unregulated health workers.
- Showering, toileting, dressing patients, feeding, diversional therapy.
- Assisting Mental Health clients in in-patient settings to perform ADL.'
- ADLs x 3.
- Chaperoning trans vaginal scans washing transvaginal probes.
- Assisting with ADLs.
- None, even the old bed bath was more than just a wash.
- Damp dusting, linen bags, bed making, some ADL's, messages, feeding patients. tidying patient areas, unpacking/packing patient belongings.
- ADL's.
- ADL care providing appropriate training has been given.
- So long as under the NBSA, safe pt ADL's, mobility, safe pt feeding, toileting, bed pans, applying moisturisers, linen bags, getting discharge meds from pharmacy, some of these could be done by ward ancillaries, except we share 1 between 3 wards and some days don't see them at all.



15 May 2006 to 20 July 2006

- Basic ADL's; all obs if trained, including neuro.; simple wounds; change IV pumps if checked; cleanliness of ward if have no particular pt. load; restock local items and report low stocks to ancillary; documentation if checked; talk to pts/families for more information, escort uncomplicated .patients.
- Showering/toileting.
- Hotel services; bed making etc.
- None, I believe the nursing assistant or carer role should be done away with altogether.
- If the role of the EN was to change to become more qualified to do RN roles, then assistants could do much of what an EN and carers would do in Nursing homes now.
- Nothing x 4 responses,
- Walking patients, sitting and communicating.
- Administrative tasks , ie paperwork , answering phones, stats collation etc, standard letters being sent out etc., admission and info packs put together- they would need to have an understanding of why they are doing what they are doing.
- Bed making, escorting clients, getting money for clients, taking out linen bags.
- Recreational and Diversional Therapy activities.
- Basic uncomplicated personal care but under the direction of Registered nurses,
- Washing beds, making unoccupied beds transfer of patients.
- Bed making, linen sorting etc.
- I don't see why a 4 hour shift couldn't be created for am weekday shifts to provide ADL assistance. This may lighten the load and allow discharge planning.
- Cleaning/stocking.
- Cleaning the pan room, restocking stores, answering phones, cleaning beds, making beds.
- Wash, pressure area care, feed patient, clean pan room.
- Checking resusc. Equipment; ADL's.
- Bed making, some ADLs tasks, cleaning and restocking equipment.
- Transportation of 'standard & straight forward' patients to & fro the peri-operative environment.
- To provide holistic individualised care, the nurse allocated the patient care can deliver the best possible care. Tasks that the assistants in nursing could undertake would prevent the development of the professional relationship which is conducive to wellness.

Responses up to 15 May 2006

- Some ADLs with stable patients.
- Cleaning patient areas after discharge. Taking patients to other areas eg x-ray. Transporting patients home. Cleaning floors Cleaning areas if there are any spills as services will not.
- I could say basic nursing care but I believe basic nursing care is the fundamental core of nursing and it is what is remembered by the client on discharge as it allows the opportunity for the nurse to connect with the client.
- Answering phones, making and cleaning beds, patient property lists, restocking of cupboards, finding equipment, cleaning of equipment, spills, Flowers-vases, water, preparing patient overways for meals.
- Patient ADLs, patient escorts, patient minding for safety, vital signs.
- Minding patients.
- Hygiene activities if they are not complicated.
- I believe there is no place for the unskilled worker as any activity undertaken by a nurse can be used as an opportunity to assess the patient and add this knowledge to the total care for the patient.
- Three levels of nursing is not a new concept. I trained in the UK when this was an established way of working. It worked fine but was very hierarchical. Again teamwork is important and overlapping of roles within scope of practice is fine as long as everyone is rowing in the same direction and is properly supervised. I think if there are third level workers in the acute system then they need to be regulated by the Nurses Board - they are undertaking nursing work after all. You do not want what has happened in aged care to happen in the acute sector. In aged care you have registered nurses doing 8 hour drug rounds or paperwork with little or no contact with the clients. The RN is dependent on minimally educated workers to feed back information about client status - this is not satisfactory the RN has to be the captain of the (nursing) boat so to speak!
- Cleaning beds, rooms, utility rooms, bookwork, ordering, answering phones.
- Following assessment and clearly under indirect supervision, all the things we teach family members to do when caring for people at home! Feeding patients. Emptying urinary bags. BGLs. Showering/bed bathing.
- Hygiene, mobilising, simple dressing changes, assisting with meals, escorting to other departments, maintaining fluid records, recording observations.
- I have concerns about transferring activities to assistants eg: Too often I see partially empty food trays removed by assistants will little acknowledgement or understanding of the fluid/balance needs of the patients.
- Bed making, cleaning bodily excretions from floors etc, some patient care areas such as bed baths, back rubs for limited patients. Filing in case notes. Cleaning/tidying store rooms cupboards etc.



- No. I am not in support of introducing another level of nursing into acute care. Nurses in this area need training in a number of areas and I do not believe that the skill of carers is enough.
- After going through assistant nursing in another state to becoming an RN and further I don't think this is a pathway that I would recommend. I realise with the shortage looming that this has become reality, but I think it also could be quite dangerous for our patients. I had no idea of the implications of what I was doing when I was a nursing assistant.
- Hygiene, feeding, pressure area care, basic observations, menus, answering phones. Theatre prep., preparation of body for mortuary.
- NIL (only if they are students in nursing).
- Cleaning, restocking.
- Washing, toileting, other general ADL's, specialising if the idea is to stop self harm, terminal cleaning, and other cleaning type activities.
- It is not about nursing assistants, it is more a case of providing assistance to nurses.
- Basic nursing care with the ability to refer on if required.
- I think many things. Data gathering for example could be delegated to assistants but the responsibility of care of that patient remains the responsibility of the RN. A task and physical application of a skill is only part of the nursing that I do.
- Midwives should not delegate to assistants.
- Cleaning beds at discharge.
- I may be considered old fashioned however during most tasks I do I'm looking and assessing. What appears to be mundane may be assisting my in depth assessment, feeding someone allows me to assess swallowing reflex, state of mucous membranes, teeth etc. so it may be great to have someone feed some patients but maybe not for others. Similarly with basic hygiene where an astute nurse identifies state of skin, nails, pressure areas, skin lesions, wounds, incontinence rash etc. Even doing someone's hair may be the only free minute in the day to get to KNOW your patient. Here is the dilemma.
- Settling babies, making beds, topping up water, directing visitors, stripping beds.
- Making beds, cleaning beds after patient discharge.
- Making beds, cleaning of room when patients are discharged, feeding patients, showering patients.

What activities if any, that are currently undertaken by nurses do you think could/should be undertaken by non clinical support staff?

CURRENT RESPONSES - 20 July 2006 to 8 December 2006 (See below for previous responses)

- Technicians could provide some tasks in relation to education of equipment.
- Patient admission documentation.
- Bed making, Cleaning, Making supper, Diversional activities.
- Hotel services (bed making), answering the telephone, restocking of equipment, assisting in keeping the area uncluttered and tidy, going on errands, ordering of equipment not in stock.
- Ordering stores, medical equipment, drugs. Paper work. Linen ordering and storing.
- Pushing barouches, getting notes from medical records, taking patients to XRay.
- Admitting and discharging of patients. There can be quite a lot of paper work when admitting a patient that could be undertaken by non clinical support staff.
- Organising notes, placing data into files, keeping patient lists up to date, taking non-urgent specimens to the appropriate place, e.g. bloods.
- Admission clerking, discharge clerking, typing, filing.
- Removal of linen bags/rubbish, Carbolizing of beds, Cleaning of wheelchairs, shower chairs etc., Temperatures of fridges ie blood fridge, vaccination fridge, medication fridges etc, Cleaning of Labour Ward post delivery, Damp dusting of equipment, Transfer of patients to and from theatre, Restocking equipment.
- Taking clients to appointments/bank etc.
- There are lots of clerical and cleaning duties still done by RNs and ENs, CSAs/orderlies often unwilling to take on some of these duties and lots of ringing and organization particularly in relation to getting patients discharged. I think this is probably the biggest area (use of non clinical staff) of contention.
- Ward clerk duties.
- Clerical activities, typing, answering phone, sliding patients on to x-ray tables, checking stock levels. Purchasing stock (special purchase req). Checking and putting away stock, maintaining consignment stock.
- Much of the administration and development of documents. eg I now spend more time in front of a computer writing up what I have done, rather than doing it. eg part of my role was writing up complex MH assessments, clerical staff saw me struggling with typing and initiated use of dictaphone. Turn around for assessment write up



was down to 1 day from 5-7. Management then banned use of dictaphone as clerical workers were seen to be doing too much typing.

- Answering telephones.
- Cleaning of beds after patient discharged.
- Arranging of transport, transfers to other facilities, answering the telephone. Photocopying paperwork, organising rosters.
- Restocking, shifting of patients from different areas of hospital.
- Beds, pharmacy runs, linen bags, collecting equipment, cleaning equipment, cordial jug rounds with a nurse for the FBC's.
- Cleaning, washing dishes, transporting patients that do not require nurse escort.

15 May 2006 to 20 July 2006

- Major stocks; phones and have people call back; deliveries of stock on time; timely repairs; equipment enough to do our job. More support from Level 4s instead of worrying about \$\$\$. They should listen and learn from all who have ideas and realise we all have different needs!! Not be dismissive or leave Level 3's to fix everything even with medical staff ie. Elective vs DOSA.
- Phone answering, clerical duties.
- Clerical, hotel services.
- Clerical duties, data entry, rosters, annual leave applications etc.
- Supervision and/or assistance with exercises, activities as prescribed, feeding, dressing, mobility.
- Liaising with regional centres and RDNS type agencies. Case Management overseeing (in terms of organising Allied health meetings and following specific criteria to get them home).
- They could do what assistants in nursing do - depends more on the individuals' capabilities within this role than a qualification.
- Case aides, diversional therapists.
- Bank runs, shopping, clothing.
- Entering data.
- Answering phones!!!!!!! Administrative tasks booking sheets etc.
- Washing beds, making unoccupied beds, transfer of patients.
- Clerical duties.
- Entering data on data base typing minute taking (these tasks are being handed over) searching for and faxing out clinical information to GP's, hospitals and community teams.
- Require extended clerical support so can be freed up from answering phones after 4pm on week days and maybe Sat mornings.
- Clerical duties - answering phones domestic duties - emptying bins.
- We need a secretary to answer phones, manage paperwork, collate statistics.
- Taking patients to XRay, theatre, phone, to the car on discharge, answering the phone, calling family on the phone for patients to talk to.
- Wash patient pressure area care feed patient clean pan room.
- Do all the packing and unpacking associated with closing wards (without lockable doors) at weekends.
- Weekend cleaning and restocking' data entry.
- Computer input of data, answering phones, booking appointments for clients.
- Booking patients to return to the wards.
- Technicians could provide some tasks in relation to education of equipment.

Responses up to 15 May 2006

- Putting phone calls through to patients, putting files together.
- Cleaning, Security after hours, Transport, Ward clerk activities.
- In the country nurses are still required to do a lot of administrative tasks which I can't see changing in the foreseeable future due to financial/human resource restraints of health units.
- Answering phones, collating notes, finding notes.
- Courier work, cleaning of patient equipment and beds, telephone enquiries, clerical duties, restocking, equipment maintenance.
- Dirty linen, feeding, restocking, running errands, tidying up, maintaining equipment, surveys, audits eg equipment checks, answering phones, beds.
- Stocking and restocking of equipment and materials. Bed making, cleaning client areas after discharge/transfer.
- Making appointments, answering telephones, dealing with enquiries.
- I think that this would be individual to each work area and already happens to a degree in some organisations. You would have to take into account the risk.
- Making appointments, escorting.
- Administrative tasks, answering phone calls and responding to enquiries.



- Filing, answering the phone, ordering, rotating and putting away stock.
- Filing in case notes.
- Making beds, cleaning beds after patient discharge, stocking of cupboards.
- None, all activities lead to therapeutic interactions.
- Coding, organisation of case notes ie.. retrieving or filing of results.
- Answering telephones, this is not done here at this organisation, all patient enquires are put through to nurses when they could be screened through admin especially if the person on the phone just wants to talk to the patient not the nurse. More of the discharge paper work could be completed by admin. At our hospital nurses have to check every meal before giving it to the patient this could be checked with what's been ordered by the kitchen staff etc.
- Answering telephones.
- Arranging flowers, getting cups of tea, menus, administrative tasks, admission paperwork, theatre preparation.
- Answering telephones and redirecting visitors 24 HOURS-A-DAY; not just 9-5. Referring clinical issues to appropriate nurse. Newspapers, TV & other "hotel services". All paperwork "arranging". A ward clerk each end of two section wards.
- Cleaning.
- Filing, answering phones 0700-2300 rather than 0800-1600, chasing results, pharmacy, doctors, and other phone and pager type tasks.
- All of the activities that are associated with providing the right environment with the right equipment and supplies: restocking, ordering, arranging repairs and maintenance and loan equipment, collecting supplies from other areas, transporting patients, emptying linen carriers and cleaning utility rooms. People to conduct safety audits of areas and follow up on repairs etc that need doing. People to answer the telephones during the evenings. Secretarial support.
- Any administrative task, Meeting minutes, Writing up minutes, agendas etc.
- Answering the phone, directing people, paperwork, setting up areas, typing, equipment maintenance, stocking, cleaning.
- Cleaning up the environment.
- Orientation to ward/room: buzzer, telephone, linen, tea room, name badge checking DOB with UR., cleaning and making beds, cleaning pan room and emptying linen carriers, giving out suppers, answering phones after hours, admission paperwork after hours, sitting by the distressed, anxious, demented.
- Delivery of flowers, directing visitors, orientating clients, filing.
- Telephone calls after hours.
- None. I do not support non clinical support staff being introduced.
- Cleaning, bed making.

Access to information: original question was changed on 9 May into two questions with clearer wording, and all answers have been amalgamated.

What level of internet access do you have in your immediate workplace to obtain information/current knowledge in your field?

Easy internet access in the work area	52%
Internet access in the work area available but limited	27%
Internet access in the organisation but not the work area	21%

What level of access do you have (in your immediate workplace) to current knowledge/professional discussion in your field of practice?

Workplace access	Easy access	Limited access	No access	Unsure
Library within the workplace	44%	23%	31%	2%
Access to online journals	35%	36%	26%	3%
Access to clinical forums/discussion groups in the workplace	23%	35%	31%	11%



If you work in a clinical role in a ward or unit, how is work allocated?		
	Always	Sometimes
By a number of patients, beds, or bays	68%	16%
BY the complexity of patient needs (ie most complex needs allocated to most experienced nurse)	34%	50%
By groups of activities (ie medications, wound care)	10%	23%
By the level of decision-making and clinical judgement needed for patient or task	31%	38%
By a mixture of the above	44%	38%

Do you have any examples of work from other departments that have become part of the nursing role in the last year or so?

CURRENT RESPONSES - 20 July 2006 to 8 December 2006 (See below for previous responses)

- Suturing, plastering, requests for XRays, IV cannulation, PICC insertion are done by some nurses in designated areas. Nurse Practitioner and specialised nursing roles have extended roles previously undertaken by doctors (ie a Nurse Sedationist role is being developed).
- Ordering stores, linen paperwork for admissions collecting long stay patients clothes for washing and putting away after.
- Inserting IV's.
- Increase in quality activities to quantify nursing practice.
- Often is shortage of allied health so nursing is expected to manage this ie some physio, social work issues, dietary.
- Increasing amount of AIMS forms to complete.
- Ward clerk often off sick and not replaced, ancillary relieving/off sick/ teaching and nursing staff fill in, damp dusting, restocking, physio not in attendance as often teaching new orderlies their job and way around. Dealing with aggressive relatives and frequent bed changes within the ward to accommodate overfull busy hospital.
- HR management. Clerical / administrative duties as units are not provided with 24/7 support.
- Spend more time filling out forms in regard to patients health cover status and admission info. Feel this should be totally left to ward clerk to attend to. Also things like midnight bed states etc - why can't this be ward clerks duty?
- Liaising with transitional care, social work, discharge planning.
- Clerical: no clerical support for level 3, but increased Admin workload.

15 May 2006 to 20 July 2006

- More forms to cover all staff; Level 4 delegate their work to Level 3's; education ie. updates because there are not enough staff "over there"; Infection control education and being asked to monitor all staff on their technique; increasing audits on same old things that have hardly changed in years. Hierarchy wants more and more projects from you; more and more student education all the time.
- Management of peripheral IV access.
- Computer work Admission and D/C on ATS/PMI system. No computer systems talk to each other, significant double/triple entry of same data.
- Performing blood tests -applying plaster -accessing indwelling IV devices.
- PICC line nurse inserters. PIVC insertion in radiology, but for a number of years now.
- Admin tasks.
- Nursing taking on HR for allied health , multi class positions assuming HR responsibilities.
- Data gathering for clinical systems such as NOCC.
- NM managing allied health HR. allied health are working seven day rosters, Team leaders who multi classed are too busy to manage the HR component of their role. nurse Practitioner candidates
- Developing nursing mental state assessments via videoconferencing of consumers in remote hospitals in country SA. Currently undertaking an accreditation process for this. Benefit will be 24 hour access by country staff to expertise in mental state assessment and in role modelling these skills.
- Maintenance of equipment registers, developing staff programs for education, there is now limited staff development support, accreditation for safe manual handling, CPR etc.
- When a condition has a multi-disciplinary approach to care. Taking blood specimens.
- Updating computer information systems.

Responses up to 15 May 2006

- After hours IV nurse; Nurse led OPD clinics.



- Performing data collection, quality activities, education.
- Quality, risk, OHS&W.
- With the advent of 3 non clinical days we were given 'projects' such as increased auditing.
- Evaluation and research.
- Multiple forms to prove to senior staff that nurses are actually doing their job. Other disciplines are not required to complete check lists to demonstrate that they have changed sheets or done a bed sponge or in mental health, sighted a patient each 15 minutes.
- Nurses sometimes answer the phone because of lack of sufficient clerical staff,
- Yes. I am 3/52 into an extended practice role so I will be taking on some medical responsibilities. I'm learning to cannulate. I met with a dietician today and discussed doing basic nutritional screening. I want to do MMSE (medical). I did heaps of SW tasks as a CNC.
- Statistics on staffing -OH&S policy, standard writing -Report writing where the information in the report is available in other areas.
- IV access, ECG after hours, some infusions.
- Public relations and promotional activities.
- Quality & safety in relation to monitoring key performance indicators.
- Walking people to Xray, HR work.
- As an educator in a metro hospital accountable for good quality clinical teaching and program development, available clerical support is diminishing rapidly. Often as an educator we are writing, typing, editing and printing our own materials for clinical areas with limited clerical support. Although at times it is best to do things yourself it takes away time to spend with the all important clinical staff, graduates.
- Quit smoking program.
- HR.
- Swallowing assessments.
- Hearing test on newborns.

If you work in a clinical role, can you list the main activities, if any, that you undertake after hours that are usually done by medical or allied health staff during the day?

CURRENT RESPONSES - 20 July 2006 to 8 December 2006 (See below for previous responses)

- Physio but this is also limited during the day.
- Intravenous cannulation. Venepuncture. Exercising/mobilising patients Preparing suppers &/or early breakfasts Social/conflict resolution.
- Answering phones, paperwork for admissions etc counselling, suppers, turning over Oxygen or changing cylinders.
- Physiotherapy, Answering phones, Locating food for patients, Cleaning bed areas, Finding equipment/drugs.
- Ambulating patients, patient assessment for all kinds of things including choking, falls, assessment of patient condition ringing medical officers to come and assess after doing initial assessment and making a judgement that the patient needs to be seen.
- Taking bloods, paper work that is usually done by the ward clerk.
- Outpatients, assessment/admission of patients.
- Majority of an after hours admission to an acute psych unit is performed by a nurse, where-as during the day this is more medically driven. Assessment and management of complex situations. Family liaison.
- Bookings, IT work, cleaning, preparation of meals.
- Emergency MH assessments that present near the end of 9-5 work day. Completion of clinical notes that relate to emergency presentations and require clinical information for other health providers.
- Patient mobility/transfers bed moving.
- Cannulation if RN is competent.
- Phones, physio, meal tray collection, counselling of relatives, referring of relatives to Drs the next day.
- Tracking down medical staff on call.

15 May 2006 to 20 July 2006

- Usually before I go home the late staff come to me with unfinished business from medical staff, in particular medication orders.
- Arranging transport D/C, planning physical exercise, chest care, lack of some social work support A/H usually delays D/C.
- Out patient appointments, getting case notes.
- Any decisions that need to be made in clinical situations.
- Assessing, diagnosing and prescribing medications - for GP's to sign off phone orders in the morning.

- Taking bloods. Physiotherapy treatment.

Responses up to 15 May 2006

- Clerical duties, cleaning duties, errand running.
- Physio, counselling, telling night resident what to do. Christmas is the classic example where everyone goes on holidays and the nurses are it for 2-3 weeks.
- Most Social Work activities (contacting relatives, arranging forms for DSS, clothing, etc).
- My role is constantly requiring out of hours work. Whether the work is done by other staff during the day I'm not sure, or whether it is the extra expectations on our roles to do more every year and not be allocated the time.
- I rarely work after hours. If I stay back I probably make medical type care decisions, but would advise the intern of what I was doing & why. (I do this in hours too). Nursing staff might recommend certain courses of action to take to relieving interns.
- Result collecting and organising management, chasing pathology forms.
- Amazingly given more leeway to perform different tasks after hours when some wish to have time out rather than be called back into hospital. IV cannulation, all mobilisation/physio.
- Mobility assessments.

What would you describe as the 'knowledge work' of nursing? List the main examples you see in practice.

CURRENT RESPONSES -14 August 2006 to 23 November 2006 (See below for previous responses)

- Assessment, first intervention, patient history, observation, medication effects.
- Holistic appreciation of the patient, the bigger picture.
- Basing clinical practice on evidence-based theoretical knowledge. Using critical reflection to guide practice.
- Mental state assessment. Mental health disorders/illnesses. Lifestyle issues. Physical health issues. Impact of social and spiritual issues on mental health. Care/treatment plan formulation. 1:1 counselling/therapy/care/treatment theories and models. Prioritising needs. Evaluating practice. Pharmacology. Stress Vulnerability models, and other models or frameworks (nursing and other) CBT, IPT, DBT etc.
- I act as a resource for the registrars and do quite a lot of teaching. I know all the equipment in the angio suite and how to use it. I instruct the registrars a lot in technique for inserting PICC lines, getting DSA images, how to position patients to get the best pictures. Nursing knowledge includes being able to assess the patient's state of health to undergo certain procedures. To be their advocate, to know how much of the procedure they can cope with, when they need pain relief/anaesthesia. to be able to explain the procedure to the patient in a simple way so they understand. The knowledge work of nursing includes assessing the patient's health, physical state, mental state and degree of compliance from the first "Hello, how are you?" to the end of their episode of care. There is much more to the "knowledge of nursing" than there is the room to tell or the space to tell it in.
- Discharge planning patient acuity staffing problems (how to identify, when to pursue).
- Assessment of patients health, assessing effectiveness of care, using the skills of assessment and observation to make sound judgements in regard to the care of patient.
- Being able to identify changes in pt's condition, behaviour- some people don't pick it up. Where to find stuff when no one else can, being able to think outside the square to solve dressings, wounds, behaviours, moving pts away from other pts, involving pts in their care, involving pts in life, fun.

20 July 2006 to 14 August

- Patient assessment; interpretation of patient signs & symptoms; prioritization of tasks & duties.
- Its the integration of the clinical assessment that results in changes to patient management, clinical problem solving skills.
- Evidence based practice. Conducting Research relevant to practice. Recognition of variations from normal. Conducting patient assessment and history taking. Administration of medication. Education of staff, patients and their families. The legalities of documentation. Aware of all the legal and ethical parameters of patient care.
- Anticipating events, REALLY listening, Empathy.
- Clinical decision making, and nursing assessment as an ongoing process. An experienced nurse is always using their assessing skills- though this is often not realised by the nurse - we often talk about intuition. The nurse knows intuitively when things are not right and the action to take. Experienced nurses often guide or direct inexperienced doctors who have not developed the clinical decision making skills. Overseeing a whole range of complexities for a cohort of patients and being able to make the connections and links with the multidisciplinary team. The nurse is like the thread that links it all together, keeping the patient central. This is often in the nurse's head. Advocating for the patient, I think this is another type of knowledge work that the nurse fulfills. I think nurses also undersell what abilities they have - the level of communication, negotiation are also aspects that we probably don't consider.



- Assessment of patients planning care and clinical practice advocacy safety of client and all staff education of other nurses /clients.
- Assessing, planning, implementing and evaluating the individual health plans for clients which includes engaging the client/family, designing Clinical Care and Discharge Plans, being pivotal, advocating the clients wishes in aligning and disseminating the multi D plan, involving & educating the client/familyin reality there is a large amount of knowledge work involved in nursing far too much to attempt to place here.

15 May 2006 to 20 July 2006

- Illness/wellness; responses to treatments; equip knowledge; priorities; complications/treatment; know resources; mainly the actual clinical tasks one does each day ranging from the simplest thing to the most complicated.
- Assessment.
- Nursing assessment, applying theory of disease and changes in pt condition to practice. Knowledge of anatomy etc in patient positioning and comfort and ambulation. Understanding the implication of changes in pt observation and acting on those changes. Applying knowledge of anatomy and physiology in wound healing applying experiential and theoretical knowledge to anticipate changes in pt condition (often called intuition).
- Application of knowledge from another Unit i.e. introduction of blood taking practices already performed in ICU in ED -rapid assessment practices already performed in Oncology upon admission being introduced in ED to speed up diagnosis of presenting situation and appropriate treatment, i.e. access indwelling IV device to obtain blood and expedite accurate treatment -rotation of experienced staff from one area to another and their having confidence/being encouraged to share their knowledge for the betterment of the patients in that area - also having medical staff support to do this.
- Recognising slight changes within the patient across a broad dimension.
- In MH: therapeutic use of self with clients. Pharmacotherapy, Physical health knowledge, psychological therapies, systems knowledge.
- Clinical practice best practice expertise from others in the field, research activities.
- Counselling, mental health nursing assessment, medication management and related practices, group work, specific therapies - eg CBT, narrative etc.
- Understanding the whole patient and their context. Seeing beyond the limitations of the medical model of the health system.
- Nurses have a great knowledge base and unfortunately their own practice of developing care plans that spell the obvious out in detail makes us look unprofessional,
- Different nurses build up different skill sets depending on where they have worked and what opportunities they have taken advantage of. I think different disciplines can offer insights to the other to expand thinking and that for this reason a multi D team that works collaboratively is a valuable thing. Nurses are useful in that we have a broad range of knowledge about most things, however other disciplines can bring much more focussed, specialised knowledge in a particular field. I think it is professional to acknowledge this and to tap in to the expertise of others. Nurses are the only discipline in our work area that are rostered 24 hours, and who have knowledge and skills to deliver all aspects of patient care, not just a segment of it.
- This question is open to any number of interpretations and is therefore meaningless! Please define 'knowledge work'. I could not find a definition or description in the paper. (NOTE: See Article Three pages 5-7).
- All medical knowledge as we have huge numbers of new interns.
- Patient assessment; interpretation of patient signs & symptoms; prioritization of tasks & duties.
- Its the integration of the clinical assessment that results in changes to patient management, clinical problem solving skills.
- Evidence based practice. Conducting research relevant to practice. Recognition of variations from normal. Conducting patient assessment and history taking. Administration of medication. Education of staff, patients and their families. The legalities of documentation. Aware of all the legal and ethical parameters of patient care.

Responses up to 15 May 2006

- Disease process, drug interactions, care planning, problem solving.
- Patient assessment, discharge planning.
- Recognising clinical symptoms along with biomedical parameters. Ensuring patient safety. Adherence to guidelines of practice. Playing the doctor-nurse game.
- Assessment skills. Ability to pick up on possible complications. Ability to know how to access and facilitate care for clients/patients. Unconscious use of problem solving and the nursing process.
- How to assess a patient and plan appropriate nursing care. Recognition of changes in patient condition and ability to take necessary action.
- The knowledge that one initially learns - the theory. Ongoing knowledge gleaned in many ways. Experience - through practice. Formal learning - through education programmes. Informal learning - listening to other experts, reading articles, modelling yourself on others etc. All of this knowledge then contributes to the care you deliver. Examples: Appropriate nursing actions according to client's condition - knowing the right thing to do,



psychological care of client and supporting family/friends, medication management, brokering appropriate care during the time the client is in the nurses charge and ongoing care as needed, managing team interactions, supervision of junior/less experienced staff, education of clients/family/ friends, education of other team members, management of resources, maintaining a safe environment etc.

- Anatomy and physiology, disease process, communication skills, assessment skills - physical, psychological social and emotional. Treatment regimes, those things that go right and those things that can go terribly wrong.
- From my point of view as a L3, the ability to apply knowledge work is constrained by bureaucracy.
- Interpersonal communications, patient centred care, medication management, wound care.
- People skills, Clinical skills, Symptomatology of illness. When to act and when to pass off to senior or better skilled staff.
- Behaviour management, medication management, psycho-education, supportive counselling, mental health assessment, crisis intervention, family counselling, agency liaison, GP liaison, referral to other services.
- Counselling, liaison with multi-d team to plan and evaluate care, client assessment, autonomous decision making.
- This is a huge question, but I think it focuses around assessment of the patient, and it's about synthesising your theoretical knowledge of the patient, what you have learnt at uni & with experience over time, with what you see happening with the patient before you. It might be a simple routine task but you are drawing on multiple knowledges at one time. It's also about evaluation too. Returning to the patient after interventions and observing the patient's progress. I don't believe I should assess a patient, delegate someone to perform a task and leave it at that. Sometimes you have to do the task.
- Knowledge of work is evident in many areas many times a day. Interpretation of results, suggestions to RMO/Registrar about management, education of RMO and sometimes Registrars.
- Able to access and join the dots, a multitude of problems the patient presents with, to create an accurate picture of where a patient is at, and when a change is occurring that needs to be worried about, versus being OK, but I see many examples of this NOT occurring, by either nursing or medicine, as we are getting people with narrow fields of knowledge, eg orthopaedics, where the patient's cardiac symptoms are being completely ignored.
- Knowing what to look for, when to act and how to act. The ability to creatively devise solutions to problems, the ability to interact with, influence and communicate with a wide range of people, empathy.
- Clinical reasoning, clinical judgements, tacit knowledge, policies, procedures, legislation, ethics, human & material resources. Interpersonal skills. Management/leadership styles.
- Clinical environment and resource assessment knowledge. Physical and psychological assessment knowledge. Physiology and pathophysiology knowledge. Critical thinking & problem solving knowledge. Interpersonal knowledge, human development and stages of life. Current evidence and research knowledge. Child, adult learning.
- Everything I do is based on my knowledge - all direct care, documentation, and liaison with others. Priority to clinical reasoning/decision making, specialty tasks necessitating ongoing study.
- Understanding normal and abnormal course of pregnancy, delivery and postnatal and infant care; education, health promotion, referral systems, ability to identify high risk problems.

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%



If there was a fully clinical role at Level 3 and above, do you have any activities to add that were not on the list in the previous question?

CURRENT RESPONSES - 20 July 2006 to 8 December (See below for previous responses)

- Co-ordinating health management of specific patient groups, including health promotion/education for this group and the community.
- Regular in-service/ update re evidence based info. Providing advice /assistance in emergency situations.
- Research relevant to their patient group. Education to other nurses and health professionals.
- Having nursing students.
- Education and support of junior staff, advocate for patient issues and the issues of staff.
- Working on the ward in times of need instead of spending an hour looking for staff.
- Input into professional development.
- Care plan reviews.
- Undertaking clinical nursing related research.
- Participating in clinical supervision, encouraging reflective practice and critical analysis among other nurses.
- Co-ordination of quality improvement and evaluation of service.
- Co-ordination of all areas of work area.
- Evaluating practice and effectiveness of nursing interventions by auditing or KPI. Being involved in practical research so that best practice clinical work is done.
- Education role, universities and staff development outside of ward area.
- Coordinates the unit on a daily basis.

15 May 2006 to 20 July 2006

- Level 4's are NOT clinical and have no right to make judgements in the clinical field! They are dismissive for the most and not very supportive if it differs from their own viewpoint! I don't know how many more liaison staff we want on board but it is clear one CNC cannot take on all of these tasks and I believe liaison nurses should often be CN's. And what is the difference in workload and "intellect" between a nurse practitioner and a CNC? Nothing to me. The NP gets more money that's all, often for less work.
- Teaching role modelling.
- Doing simple operative procedures. Clinical education to hospital staff (nurses, doctors and allied health).
- Clinical supervision of nursing staff.
- Provide clinical supervision for other nurses, mentoring role, promotion of profession.
- Detention rights. Ordering of tests.
- Discharging patients, particularly on weekends and public holidays.
- I think it should be an advisory role with a pure clinical focus. Divorced from the day to day routine patient care but to provide education of staff and advice whilst developing big picture clinical direction for units ie philosophy.
- There would need to be some consideration about how this sort of clinical role would sit within a team, the lines of governance, and accountability to ensure it does not set up "lone rangers" who do not have a responsibility for the overall quality of service delivered, or accountability to the rest of the team. Having said that it would be a valuable role if these issues are thought through. Often times current level 3 workers are juggling clinical and managerial work, and the demands are difficult to meet.
- Discharge planning champion/ coordinator.
- Nursing roster.
- Ordering of investigations based upon patient assessment, interpretation of results of investigations ordered.
- Conducting relevant research. Publishing the information in journals. Presenting at conferences.

Responses up to 15 May 2006

- Planned staff education/updates, provide current data, research information.
- Staff education, resource investigation re appropriateness of materials used.
- Acceptance by medical staff as an equal partner.
- Admitting rights where appropriate eg Palliative Care - the nurse is on 24 hour call - she/he has a client who needs urgent admission for pain management during the night. The nurse should be able to admit in their own right - under agreed protocols. In some cases the client may need only nursing care - why include the doctor if there is no need to?
- Developing and implementing patient care pathways on admission.
- Interactions with carers/relatives. Interactions at senior level to inform staff and have input into decisions. Bottom up and top down interactions.
- Developing nursing care plans for individual patients.
- Research, clinical leadership, input to multi disciplinary groups.



- Education for staff in best practice and the implementation of any protocols.
- I consider a ward CNC does this to a greater or lesser extent - it's just determined by the setting.
- Staff education and support. As many level 3's are counted in the numbers on days of the week perhaps time to do patient care would be good!
- Medication charts are a pharmacist's role in this modern world of 8000 different drugs. Not even medical staff get it right. No protocol can focus on a professional role, as all patient treatment will be multi-focused.
- Providing education to the patient, other nurses and the multi-d team.
- Education & succession planning.
- Expert clinician, clinical teaching at the bed side, role modelling evidenced based practice, evaluation of patient care and patient group outcomes.
- Role model to level 1 clinicians, showing how to do, act and resource and problem solve.
- Establishing ongoing learning and progressive culture in ward mentoring novice and experienced nurses. Establishing forums to discuss professional and clinical issues. Extending staff to reach their maximum potential. Be involved in patient surveys inviting their involvement and meeting some previously unmet and unrecognised needs. Similar with staff survey and needs. Education sessions. Responsive to professional and clinical needs. Counsellor to assist staff with their own development.
- Discharge of women writing discharge letters faxing referrals signing pathology writing up diaries.
- Undertaking research.

If there were more clinical roles attached to a clinical specialty and working across hospital and community locations (say on a rotation of a few weeks of each), would such a role be attractive to you? Please indicate yes or no and give your reasons.

CURRENT RESPONSES - 20 July 2006 to 8 December 2006(See below for previous responses)

- Yes. In my area of practice, I believe a consultant approach position would be optimal. It has already been recognised by GP's in the community the difficulty of getting access to adolescents, especially in relation to depression/suicidal ideation.
- No.
- Yes, but I ideally I would like to co-ordinate this type of service (aiming high aren't I?).
- Yes, it would enable a better understanding of community services. This is the trend for health care - it will assist clinicians in the acute setting to see some of the possibilities.
- Yes as a midwife it would maintain competency and also could provide services where there is a lack of midwives.
- Yes I think something like this would be excellent I am of an age where I would like to pass on the experience and expertise that I have. The free movement of ideas and knowledge would only be promoted across nursing and various institutions with face to face hands on interaction.
- Yes. I already work a patient load on the ward and then do community home visits.
- Yes- differences between hospital and community locations would enhance knowledge of the clinical specialty area and there must be better outcomes for patients by having more in tune nurses. Greater communication and enhanced continuity across both hospital and community care.
- No. I have been nursing for under one year so I don't feel that I have the experience for this.
- No - not interested in clinical role at this time.
- Yes, because I value diversity & seek to increase my skills & knowledge base in a variety of areas. To maintain interest.
- Yes, I currently need to work for a nursing agency to have this sort of flexibility in my practice.
- Yes, chance to opt out of shift work for periods of time would be attractive and involvement with people in their environment instead of in hospital setting.
- Yes, I already do a very similar role as I am a clinical nurse manager and I love the clinical part of my work.
- YES!!! A career path at last that doesn't require the abandonment of what I do best: Clinical MH Nursing. In various work roles especially ACIS, nursing have already done much of the list above with the support of Psychiatrists. Just have not been recognised in level, pay, or role description.
- Yes, the diversity would be good for benchmarking and learning. It would also improve services as all areas would contribute to work toward one central goal. It would also get me outside these 4 walls. (ha ha) Seriously, it would help retain burnt out staff.
- No - would feel like you don't belong anywhere. And when people don't belong they don't have the same commitment to the service as those "rotating" through the service.
- No - may lead to lack of continuity of care.



- Yes because it enables you to get a honest perspective of what the role involves and maybe being able to introduce change.
- Yes, but I'm only an EN. I'd like to be involved in anything to help develop and evolve the EN role in SA.
- Yes, a nurse led pre-operative clinic where the Nurse coordinates necessary pre-op workup as currently Drs not meeting all requirements. To get an overall picture of how well the system works and being able to identify shortfall or system failures first hand and be able to address issues in a timely manner.

15 May 2006 to 20 July 2006

- If you like what you do then why change provided you are good. However at least experiencing a range of roles in your specialty would be good. No if it's only for a few weeks. What could you possibly stabilise in that short a time? Yes, if I needed to take some time out from the hardest job nursing faces today, CNC of an acute ward. As usual no-one recognises that and good leaders leave.
- Unsure
- Yes, would increase job satisfaction through greater diversity in nursing practice and development of a wider body of knowledge and skills.
- Yes, this provides a way to maintain clinical skills, bring back evidence for future planning of care / development and update of protocols, appreciate the patients home environment, maintain credibility, show that 'practice what is preached'
- Yes - If it were the only way these roles would occur. No - I am an expert in my field and I do not need to share the role for difficulty, I just need the role created.
- No, too confusing because everywhere has their slight variation/interpretation on things and it would be forever altering.
- Yes, but more than just a few weeks at a time as that would not allow for any continuity with clients.
- Definitely.
- Yes in mental health many nurses work in either or (Hospital /Community) working across both will improve discharge planning and risk assessment.
- Yes dependant on how that role is developed- I should determine the experience I wish to get.
- Yes.
- I am content in my current role, however if I was looking for something else this would be an attractive option.
- A few week rotation role may be difficult for the staff to settle into role and be proficient at it. Patients like a degree of familiarity with community outreach programs and sometimes are less open with a stranger as no rapport.
- No.
- Yes, I like challenges and variety.
- Yes - a combination of hospital-based and community-based activities would be satisfying and allow a better appreciation of the patient journey towards health/well-being.
- I work in such a role currently and unfortunately a rotation of a few weeks is not long enough. Another important factor to consider is continuity of care for the patient. This is a really important component of advanced roles, so if you see a patient in the community setting you need to try to keep doing this at least for a decent period of time, it also makes your life easier otherwise you are continually starting from new with a patient if you are swapping sites.
- Yes because you would be able to assess the client home and family situation which could affect the clients health outcomes.
- Yes. In my area of practice, I believe a consultant approach position would be optimal. It has already been recognised by GP's in the community the difficulty of getting across to adolescents, especially in relation to depression/suicidal ideation.

Responses up to 15 May 2006

- Yes (with no reasons) by two responses.
- A few weeks would not be a long enough time, maybe if it was a 6 month rotational position.
- Yes, because we are not doing enough in prevention of diabetes and renal failure. We only deal with medical crisis and leave the patient to know when to seek medical help. Often that medical help is not easily accessed and could be given by a nurse.
- No, as rotations may well be disruptive to skills. Would need more information on what this really means.
- I have already done such a role in the past - I have moved on from this now into education. Having worked in such a role I would have some suggestions about the length of time one needs to be in the role. Rotation into the community needs a reasonable length of time as you are working with community organisations and it takes time to make trusting relationships particularly with GPs. I would suggest a rotation of initially 6 months and then ongoing every 3 - 4 months. This does work and enhances the nurse's knowledge greatly. The clients may also see the nurses in more than one location and they often are pleased by that - they feel safer and more connected. It creates community.
- Would be great for diversity.



- Working across both hospital and community alters dramatically health workers perspective. Relationships with patients/clients alter once you have been received into their homes. Your care is better when you have an understanding of their circumstances.
- Difficult to say at this time - probably but I suppose it would depend on the actual role.
- Yes. Opportunities for broader experiences, increased understanding of a range of roles and responsibilities and areas of work, perceived better patient outcomes.
- Yes. Some diversity promotes learning and increases skill. It also provides opportunity for others to learn in my role and provides a substitute should I be promoted. Such rotation should be at my request only as forced rotation has no benefit to the organisation or me.
- Yes, as long as the working arrangements that I currently have (ie 4 days per week) could be accommodated.
- No, community mental health skills are specific to area of practice. The case management role depends upon a trusted relationship with the client, this may take weeks or months to establish. Those who promote this idea do not seem to understand the needs of community mental health clients.
- Not really as you wouldn't get your teeth into the role and you would need at least 6 months to feel like you have accomplished something.
- Yes to broaden skills and knowledge of the way different organisations do things. They may operate on a different philosophy. It would be good to be exposed to this, and improve my own practice in my setting. To better understand the patient experience along the continuum. To better understand my colleagues input.
- Yes I believe that there is a difference between being a manager and being a Clinical Specialist and I would like to see this introduced.
- No, many people work in an environment because that is where they want to work. Cross campus work is not appealing, and there would be disruption to private life with logistics of further travel, parking issues, new environment stresses. This is something we have visited in the past on a volunteer basis with no takers from our area.
- Yes, but doing community would need to not be an inconvenience, ie a supplied car, from the base hospital, or a base community centre, so one has a base as it were to work from, where the team can meet and etc.
- Yes, chance to use all my skills, chance to challenge self using skills I have in different environs professional development and growth take nursing "out there" chance to see new opportunities.
- Think this could be great so long as it did not cause disruption and upheaval due to lack of continuity. Difficult to work in practice though benefits to community to understand and overlap everyone's role would provide better continuity for patient. How could someone else though deal with your workload whilst away? May find yourself playing catch up after each rotation which could be too tiring. General concept though progressive and has merit.
- Yes. Autonomy and care planning for patients by a clinical nurse expert.
- Yes, I will be able to use my skills or develop my skills, be interesting and challenging.

What are your views of the issues if nursing rosters were done by the CNC?

CURRENT RESPONSES - 20 July 2006 to 8 December 2006 (See below for previous responses)

- Our CNC already does them and it's OK.
- Depends on the CNC - wouldn't be a problem with my current CNC.
- This would enable better consideration of the skill mix rather than years experience, which often doesn't reflect ability. However it would mean the CNC is less able to do the clinical role and this would detract from an already overloaded role.
- They are.
- I believe whom ever does the rosters should have some idea of the abilities of the people they are rostering knowledge is not something that necessarily equates to years of experience.
- I think rosters are done most effectively by CNC or CN as they are intimately aware of unit requirement, staff preferences and needs. Since our CN has been doing our roster, staff satisfaction has improved.
- Nursing rosters should be done by the nurses involved i.e. self rostering.
- Some flexibility to cater for requests, some favouritism may occur in cases, better understanding of shift work.
- CNC does do the rosters on our ward and it appears to work well. One problem could be bias toward favoured nurses.
- Very biased, only the clique group would get what they want.
- No issues.
- Good idea.
- Rostering is not a clinical role, however, whoever writes rosters needs a thorough understanding of clinical issues and needs.
- Nurses much more aware of skill mix and nursing needs and I think is more personal and user friendly for the staff.



- They are already.
- I think it would be easier for CNC to teach students and buddy non performers with experienced staff if they did own rosters. More control of the clinical expertise but would need to work well with nurse manager.
- They are in my area.
- More free time for clinical support.
- CNCs know their staff, and personal requests and why and can often be negotiated both ways. The negative side can be that you cannot please all of the people all of the time, someone has to do night duty. Some staff may view some rosters as favouritism.
- Should be done by the NM.
- A CN could do this just as well.
- My workplace claims to have family friendly rosters - but in practice this is not true.
- Believe CNC could do rostering providing favouritism game did not happen.
- I think it would solve a lot of problems and stop a lot of nurses leaving all together. The CNC knows everyone's strengths and weaknesses.
- If the CNC is capable. It is a fine art to be able to produce a family/staff friendly roster. I think it is better achieved within the unit than by an outsider.

15 May 2006 to 20 July 2006

- Only if you get rid of NM because it would be another job heaped onto the CNC. Better done by a CN. You do not need a level 3 NM to put in data and for the most, give staff a hard time. Pay them less.
- Would impose a major admin load on a clinician.
- The advantages would be the intimate knowledge of the people and the area, but this takes time away from the clinical focus of the CNC role. The role would become purely management which is wrong. The advantage of NM doing the rosters is they develop excellent knowledge of individuals and area and provide balanced rosters for area need and competing individual need, and a greater oversight of the needs of the hospital as compared to a single unit.
- The CNC has a clinical management role. Doing of rosters requires IT and HR knowledge, which will take the CNC away from the clinical management.
- As per SRN days advantages of knowing staff appropriate mix/experience disadvantages managerial role and therefore leaving the reality of the coal face.
- Would probably be good as have a greater understanding of the impact of shiftwork on nursing staff and so the dreaded late/early shift may become a thing of the past. There ARE alternative roster patterns that can be utilised which eliminate the late/early completely (unless staff wish to volunteer for them), I just think those that currently do rostering don't want to bother seeking alternatives.
- Bias towards/against certain staff -wastes time that could be better used in pt care or planning of such.
- Possibly nil. Have seen it done well. Possibly a conflict of interest if CNC has good friends that they do the rostering for.
- They currently are.
- Much more appropriate - gives the staff a feeling that they have a say - closer to the work place.
- May lead to deskilling of staff in mental health as it makes rotation of staff more difficult.
- Would take time away from the current role which is already overloaded.
- CNCs do not have the time to spend on ensuring rosters are done. To get a balanced roster, you need to be aware of the award and skill mix requirements, individual need, clinical needs, staffing backfill etc.
- As long as the CNC was trained for the job and understood rostering parameters and industrial guidelines - however, in wards where there are Clinical Nurse Managers in place, the complaint is that the job is too big, and generally the clinical workload suffers as a consequence.
- Amount of time taken away from clinical area by doing paper work and allocations arranging staffing.
- Why have a nurse manager then? CNC's should not do rosters only advise their manager of clinical needs in relation to rosters.
- Nursing rosters are done in consultation with CNC's. I am as a band B level 3 nurse allowed to do rosters independently, but choose to work with the area nurse manager on them.
- Works on some wards, more flexible rosters. Makes the CNC the bad guy on some occasions. Role as it currently stands too big to add this in some areas.
- Probably would know staff and their preferences Should ensure good skill mix.
- Less flexibility.
- I think they are best done by someone who knows the staff and is aware of issues with the rosters. May be subject to favouritism or overly influenced by strong personalities in the ward.
- Our rosters are done by the CNC I think they should be done by CN staff who actually work the different shifts.
- I like the roster were done by the CNC.
- I think that the CNC would have a unit specific focus and may or may not develop an appreciation of the division's or hospital's needs. The CNC of a well resourced unit would have a distinct advantage over another unit that has



significant vacancies and roster shortfalls. They may also find it time consuming and not a lot of job satisfaction in trying to keep their staff happy.

- Takes the CNC away from the clinical area and this was meant to be their focus, rosters are not just about getting the numbers right, there is all the other work that comes with the NM role, such as Workcover, budgets, sick leave, recruitment - who will be doing this. Since the last EB and the CNC being given their non-clinical days they have just been able to catch up and started to put in place great clinical changes and support for junior staff. Don't turn around and muck that up, we need clinicians who can guide and teach our new staff.
- They currently are done by the CN.
- Our roster is done by our CNC and they are the pits. No thought is put into what staff are working, as we work from a request roster which sees the group clique getting their requested shifts off and the rest of us just fill in. Some staff only work particular days and no nights so hence the full-timers fill in around the part-timers hence working up to 8 shifts straight.
- It is done currently by the CN and 'rubber stamped' by the Nurse Manager.
- They are.

Responses up to 15 May 2006

- They are at my organisation, still need to meet the organisational needs but are more able to input staff requirements.
- CNC does roster in the country.
- They are currently done by the CNM.
- As a previous CNC I think this is a great idea, you know your staff better than anyone else and are able to roster accordingly: you are also more readily available to clarify rostering issues.
- Not a good idea as it is impossible to remain neutral and answer to the loudest voice
- I believe CNC rostering would delete the time clinicians have to spend at the bed side, and any management role will always overtake the clinical, as staff want answers now and staff require far more counselling than they did previously. When rostering there are many considerations to be aware of if staff retention is to be maintained at the same time as meeting clinical needs.
- I don't think the CNC has to do the rosters - it can be delegated to one of the team. Self rostering works as long as you have an assertive person who manages it! Nurses are no angels however if they feel that they get about 75% of what they want they are usually happy! There would need to be education of the roster person and the team about the rules though! Believe me I have done this at a ward level - the roster person is the most important person of the team! If you keep the team happy - all is well. CNCs have enough to do - it depends on whether this is important to them.
- There are issues: lack of continuity with staff as we use a lot of agency, getting staff for sick leave, and trying to stay in budget.
- Not all CNCs have the right traits to undertake rosters. Rosters should be done by people who can do, and enjoy doing rosters. Some people are extremely skilful and able to accommodate multiple requests and unit needs.
- I do our rosters sometimes, and it's far too time consuming. In the UK rosters are always done by ward staff as the Resource Nurse Role does not exist. Rosters tend to intrude into home time, it can be complicated to figure out PDOs and it is simply a 'task' that doesn't really require a L3 nurse's skills to do. There are several computer programmes that can do them.
- Rosters can be complex. People either enjoy doing them or they do not. Some people regardless of their level of expertise are better suited to this role. CNC could delegate this role to L2.
- A Manager (dedicated to the unit) should do the rosters in conjunction with the CNC. A Manager fulfils countless other tasks and is necessary. The CNC should have the freedom to do CNC chores but should have input to ensure staff skill mix and ratios are adequate or better.
- I am a CNC with little time spare for rosters etc currently. If there was a change and I had to do rosters, then I would have no time to be out on the ward for discharge planning, care planning, ward rounds, role modelling, working with students etc. My role would have to be full time administrative and no time clinical (ie not counted at all in numbers).
- Ours are done by a clerical officer in consultation with the CNC and Team Leader, this works OK but we don't have shifts so it is mainly to have a balance of staff through leave times.
- Our nursing rosters are done by the CNC, and if anything my experience throughout my career is that the better rosters were ones done by the CN's.
- More logical if it is done by someone who has regular patient contact and who has a good feel for the issues facing staff at that time.
- Absolutely against it! We've got enough to do. We should be focussed on improving patient care!!
- It would be good.
- They are! More worker friendly rosters with the CNC having the knowledge of the people and their issues.
- Waste of time and space. Rosters can be done by a competent ASO with CNC input in how they prefer staff mixes to look.



- Having done this in the past I found it worked for the team and myself and the unit. It can be problematic and time consuming if you do not have principles around the rostering which ensures rostering issues are a shared responsibility across the team and not just the CNC's.
- None.
- No problems, you could train anyone to do them, at least the CNC would know the staff, skill mix, and the problems of shift work.
- If this were part of that role description OK however it would extend or significantly change that existing role and one of the most significant issues for staff is an accessible, visible CNC. Aside from the fact that a consultant level leads clinical practice change, and research.
- May have closer interaction with members of own team.
- Lack of senior staff vs junior staff too many requests.
- It would detract from the clinical focus, which with the IP days CNC are just getting right and providing the support and focus for staff that they should. The rosters would consume the available time.
- I believe that if the rosters were done by the CNC then you would lose the clinical expertise on the wards. I believe that rosters would consume my role and that there would be little time for true clinical teaching, role modelling, care planning and staff education. Clinical credibility will also be at risk as time away from the clinical area would increase.
- No, they are out of clinical area 3 days a week, with rosters in their portfolio, we will not see them in the clinical area, such a shame when their clinical skills are not shared with her staff Delegate to the clinical nurse to broaden their management skills.

What are your views of the issues if nursing rosters were done by Human Resource Department staff?

CURRENT RESPONSES - 20 July 2006 to 8 December 2006 (See below for previous responses)

- They do not have a hands feel to the patient needs.
- No way - the staff would not have any idea of the major issues or the empathy to provide suitable rosters.
- HR would be further removed again - I don't see that this would lead to improved rosters - probably the reverse!
- Not relevant at this site.
- Only if the HR person had a nursing background/knowledge.
- It could be interesting to trial this, and see if rosters and staff satisfaction improve.
- Have experienced this and it was a disaster.
- Not nurses, don't understand shift work, may be fair but not as much room for flexibility.
- They have limited idea of what happens on the ward, how people work together, how much experience each nurse has. I don't like that idea at all.
- Not on.
- What HR Dept? We have none. Insufficient knowledge of individual nurses skills levels.
- Bad idea.
- Fine. If they have consulted clinicians in developing the roster model.
- Detachment and lack of insight in nursing needs.
- They would have no idea of skill mix and relevance of same.
- I do not think this would work. HR would not understand the complexity of some patient care or able to assess the nursing skill required.
- Lack of knowledge of skill mix. Requests not taken into account.
- Shouldn't be a hassle as long as clinical issues are identified and entered as variables.
- Not good at all.
- Not supported at all. Rosters need to be done by nursing personnel who understand skill mix issues, staff availability / flexibility etc.
- No understanding of the acuity of each patient or their care needs. This is definitely a bad decision.
- Couldn't be any worse that what we have now.
- Believe need someone with clinical experience as sometimes human resource staff member may not have the necessary knowledge in regard to skill mix issues. People just a number on a page.
- They wouldn't know who to put with who for the best pt care and outcomes.
- Bad idea.

15 May 2006 to 20 July 2006

- Don't like that because a nurse has to do the roster to understand what nurses need. CNC's still need control over changes that suit the safety of the unit and if the CN was doing them, then that's OK.



- Lack of understanding of 24 hour service issues.
- This is a bad idea. HR areas are always short staffed and have many changes in personnel. The rosters should be done by nurses with intimate knowledge of the area they are rostering for and the people in them.
- Absolutely not. The HR dept can't even cope with advising on nursing issues. It takes nursing knowledge and credibility with the staff to do the rosters.
- Appropriate.
- Mixed view really. HR staff are a bit detached from the impact of shiftwork on nurses health and social life so may not fully be able to comprehend what nurses would see as a suitable or good roster. On the other hand, again, the late/early may become a thing of the past because HR staff would (or should) be up to date with legislation relating to work hours and understand that the late/early does actually breach hours of work conditions in the award.
- Lack of or limited knowledge of unit's workload and the 'diary' of it through the week -lack of or limited knowledge of individual's ability therefore inappropriate staff mix - \$ driven rather than quality.
- No idea on how hard it is to work Late Early on a seven day continual basis.
- Absolutely no - they don't have the ward perspective or the caring factor for shift workers when they are never around those persons.
- Too far - not the same as rostering 5 day week.
- Will they be able to match staff skills and experience with unit needs?
- Depends on their background and knowledge base.
- Nursing rosters is to be done by NM as they are HR in nursing management and in consultation with CNC.
- If they understood the nursing issues - most do not. It would have to be made clear that the role is specific to rosters only - could only be done in advance, would still need someone to do the day to day backfill for sick and other unexpected leave, as well as the other duties NM's undertake.
- Nurse manager does a good job, needs to be done by a nurse.
- No understanding of staff needs.
- No.
- There are issues of ensuring you have the right balance of staff with appropriate skills and expertise. This could be addressed by formalising performance development and including this as part of the rostering data base. I think the CNC should still be consulted.
- Taking this away from nursing will take away lots of the flexibility. Requests get overlooked now, would probably be worse as they have a detachment from the area and the clinical needs of a unit.
- Would totally lack knowledge of levels of experience. Would not be appropriate where good skill mix is required.
- I feel they would not comprehend the need for adequate skill mix, and the need we have for requesting shifts to provide for family and life style.
- Would tend to be less flexible to staff needs and requests but also less vulnerable to favouritism.
- No. they do not have any idea about working shift work.
- No as they would not know the staff who work on the ward.
- I think that non-nurses have little or no idea of the complexities of nursing rosters. Our HR dept is sadly lacking in basic HR expertise at present and it would be a 'dogs breakfast' if they were to attempt nursing rosters.
- This is a scary idea, they struggle to carry out their traditional responsibilities let alone add additional responsibilities.
- They would not address individual requests.
- I think this would be great as there would be no favouritism.
- Would be acceptable providing they consulted area staff prior to publishing a roster to ensure skill mix was appropriate.
- The personal approach. CNCs have had to be on the other end of rosters in the past, and therefore sympathetic.

Responses up to 15 May 2006

- Less humane.
- Concerns about understanding of issues in relations to shift work.
- Don't understand the complexities in nursing rostering, ie. the staff mix. Even though a nurse could be considered a senior they may lack the skills and knowledge and clinical decision making to operate at this level.
- Not a good idea, less flexibility, less recognition of actual skill set. Year 9 RN on paper does not always equate to Year 9 in skill level.
- I think a basic roster could be done by a non-nurse, but it would need to have good guidelines which had been developed by a clinician in the first instance.
- Absolutely not, but if they are game its worth a try.
- Rostering can be done by anyone, but the understanding a nurse has of the role of nursing is invaluable in rostering. This would be evident in the skill mix and changes that may need to be done after the original roster is set. Rostering is not time consuming but people management is.



- Oh God no! It is much better done at a local level - it contributes to team cohesion. The only way it could be done at that level is if fixed rosters were brought in - this would only happen with a fight! Nurses moan about the rosters but in reality they love the flexibility! We just need to erase the late /early patterning that is somehow inbuilt into ProAct (for those that use it)!
- They don't understand idiosyncrasies of nursing, we don't have human resource people.
- If the HR staff have all the information and it is the right person for the job they would be able to turn out a beautiful roster?? (well beautiful is a bit unrealistic but certainly a workable roster that pleases most of the staff).
- Haven't got a problem as long as they were aware of relevant criteria such as skill mix.
- I have concerns about this concept. Could work if HR has a good understanding of the needs of that work area - may be more effective in small hospitals where staff are well known.
- Chaos.....
- I believe that the Human Resource Department here is already in disarray so would have no confidence in their ability to plan a roster. Currently the nurse managers recognise the skills of nurses and where they are professionally in order to produce a well balanced roster. My nurse manager does more than just rosters though and it is important for her to be involved in Work Cover issues and under performance issues as well.
- No this needs some clinical input unless a fixed complement is envisaged.
- I think you need to know your staff on an individual basis to get the right skill mix. You could have two staff having the same experience but one more confident than the other or one more ready to take more responsibility than the other. HR may also not be aware of any other periodic stressors that may be affecting you, and your capability coping with different stressors as the ward is more likely to know.
- Lack of clinical insight- potential for major problems if inappropriate staffing mix is applied.
- They don't understand nursing. They can't even get IR right, they pussyfoot around with that.
- This would not work.
- No, they need a nursing background to understand the issues around doing a roster.
- Absolutely, but needs to be accessible by CNC, not in some building miles away from the ward areas.
- This could make for some interesting rosters - if your rostering was fairly fixed and stable not requiring a lot of manipulation or input then this would probably be achievable.
- Already are in consultation with other level 3 staff.
- Oh no. You need responsibility across the team.
- No problem.
- Human resources would not have the same insight into the needs of the ward as the nurse manager.
- Too removed and impersonal.
- Not enough understanding behind nurses life, not taking into account requests, not doing a likable roster.
- Our HR dept currently cannot do their own job, why would they be able to do this better than a nurse manager?
- I think it is important to have a nurse do the rosters as they understand clinical need as they have worked in the environment. Would not like this impersonal approach.
- Definitely not, you need to know the different skills and understand nursing to come up with a roster that can cope with the complexity of patient care. Roster is not about numbers.

What are your views of the issues if nursing clinical performance measures were audited and/or managed by nurse managers?

CURRENT RESPONSES - 20 July 2006 to 8 December (See below for previous responses)

- They do.
- Co-workers should have input (anonymously if need be).
- Nurse Managers would need to have credibility to do this. They would need to have a greater clinical presence to do this fairly.
- Nurse managers should not have a role in managing clinical performance measures. They do not work with staff on a daily basis as a CNC does, and have limited understanding of staff performance and development.
- Nursing performance should be audited by one's peers.
- Some nurse managers have not actually done any hands on nursing and therefore are not up to date with latest clinical proformas.
- Don't mind if the nurse managers have a realistic view of what goes on on the wards and how busy it is for the nurses that work on the wards.
- They only have opinion of CNC or CN who may not be considered competent by the ward staff. If you're going to judge someone you should at least see their work.
- Should be done in conjunction with CNs.
- Fine.
- Should be a CNC (clinician) and part of developing mature, professional reflective practice.



- Should be done by persons not detached from working environment.
- Only relevant if managers are clinically competent.
- It would depend if the nurse manager was involved enough at a ward level to know the nurse to evaluate her.
- They are in my area.
- Great! more time for clinical work.
- I don't have a problem with auditing them, but think they need to be performed by clinical manager.
- Need to be managed by the CNC or clinical manager of the area.
- Fine.
- Performance audits work both ways - staff at RN L1 should have the ability to performance audit their managers.
- They wouldn't know us personally and may only get a glimpse of someone's abilities and skills.
- Not necessarily a good thing. They should be there for support in performance management, but not take over unless requested to do so

15 May 2006 to 20 July 2006

- Give them something to do that actually relates to patient care again. It would leave the CNC free to give and help her staff give the best care they can. Mind you it would be interesting. The oldies wouldn't come up with much.
- Nurse Managers do not have current clinical experience so no.
- Not sure what is meant by this question. Is it asking if NM should audit? If performance appraisals the I would say no. In fact No would be my answer to this question no matter what it means. The CNC should do that.
- They would need to have credibility in this process by maintaining the audit relevance.
- Good idea as long as clinical staff had input.
- No idea of the input put in behind the scenes into questions not covered in the performances appraisals, and the interaction with other staff in the area.
- Not always effective if the nurse manager has a personal problem with you.
- Sounds a bit fuzzy.
- Current experience is that CNM is what exists so this is already occurring.
- NM assist the CNC's with clinical audits, performances.
- Audit - OK Managed - depends what this means. If it means completing the appraisal, then no. It should be someone who has regular and close contact - eg CNC/CN.
- Nurse manager worked at a lower level than me. Would prefer my appraisal done by a senior.
- Some performance things that are easily measured could be done by nurse managers but clinical performance should be the domain of senior clinical nurses.
- No.
- I am keen on collaborative work. I have developed performance measures in consultation with the staff themselves, wider multidisciplinary team and the area nurse manager. This ensures that appropriate areas are being addressed.
- May very well be more likely to be completed this way in a timely fashion.
- I feel they would not have adequate day to day contact to make proper assessments.
- Most of these people do not work shift work and have no idea.
- Nurse managers are nurses and I believe that they have a very good understanding of the clinical performance indicators. They also work collaboratively with the clinical staff to interpret the data.
- No problem as they do it now x 2.
- Appropriate.
- Why have a CNC if they can't manage their own staff?

Responses up to 15 May 2006

- Excellent.
- I think they could assist but I think this is more meaningful when done by the staff themselves, otherwise they are just being told how good or bad they are performing.
- No, you need clinical people who are working alongside to do this.
- Depends on the clinical performance measures which are being used.
- I think these need to be done in conjunction with a clinician to have credibility.
- Neutral.
- They are.
- In this unit they are. Ownership of audits by staff would be fantastic. Asking managers to do the audits perpetuates the 'them and us'. If all nurses would be involved the results would be better. There would be ownership not imposition.
- Think it's an excellent idea and we should be doing this anyway.
- Acceptable provided the measures were applied by clinical staff or the manager is a clinically based person with expertise in the relevant clinical area.



- It would depend on the clinical ability of the nurse manager. Some nurse managers have been out of the clinical area for awhile and would need to be upskilled in this area.
- We don't have any.
- Clinical performance measures should be part of your appraisal process and professional development so they should be in order anyway. Some notice should be provided though.
- Not too many issues here, as long as the Nurse Manager's knowledge of the area being audited/managed is current.
- GOOD. They don't really know how a nurse performs clinically, but their input would be great by making sure the appraisal is on a regular basis. Also you see a different side of staff as the Nurse Manager and this should be incorporated into appraisal (ie professional role).
- This would need to be done in consultation with the clinical specialist.
- No, they are not there to do a fair assessment. Often the CN's are the best for reviewing clinical performance.
- Why have nurse managers when you have a CNC, and CN's?
- I do not have a problem with this and this might be a way of involving this group in more clinically based issues.
- No issue, already are doing it.
- I would consider this, however the current nurse manager role would have to be educated significantly to be capable of performing audit measures half well.
- Not connected to the clinical area.
- Should be reviewed on a ward basis.
- Quality is everyone's issue, nurse managers could certainly be involved with CNC.
- Have issues in relation to clinical competence of auditors.
- Not a good idea, they are not in the clinical areas observing you, and anyway most of the nurse managers have been in the job for so long that they have lost their clinical skills.

What are your views of the issues if equipment and stores were managed by the CNC?

CURRENT RESPONSES - 20 July 2006 to 8 December (See below for previous responses)

- Our CNC does them already.
- Again this detracts from the Clinical focus of this role - yes these are important for delivering care but should be the domain of someone else!
- They are.
- CNC's have a broad understanding of the requirements of their area and their patients they therefore have the knowledge to manage the store appropriately. On the down side this can often take a large chunk out of their working day.
- Our equipment and stores are currently managed by the equipment CN. She does a wonderful job, but often does unpaid overtime, as she gets called in to assist with patient care, when she is rostered to manage equipment.
- Equipment and stores can be managed by an EN.
- Yes I believe that is a good idea so long as they don't had ball it to the nurses on the ward working with the patients.
- Can't manage the client/nursing requirements how are they going to cope with more work.
- Excellent idea, in consultation with manager.
- Could their time be better spent?
- Could be a non-nurse. takes CNC away from clinical work.
- Don't think this needs to be directly done by clinical but would require good communication for meeting of needs in regards to equipment and supplies.
- I manage our equipment and stores and it takes a lot of time. I think it should be done by non clinical staff under direction from CNC/CNM.
- They are in my area.
- CNC has an overall picture this is a good idea.
- Waste of time, Clinical Nurse Consultants should be practical nursing staff.
- Believe this is not a duty requiring CNC expertise once necessary equipment and stores have been identified needs to use a system where stock is ordered once the numbers are down to specific level. However where new or additional equipment is being resourced then believe need someone with appropriate clinical practice to identify is the new stock or equipment appropriate for that specific workplace
- Great idea, then we would have stuff before it ran out! And wouldn't have to beg for stuff we need.



- This is a huge problem in the Operating room of my hospital. Too much time is spent ordering equipment that should be bar coded. Storage of consumables and space are also a significant problem. Nurses putting away consumables as they arrive is a waste of nursing resources

15 May 2006 to 20 July 2006

- We should say what we need and that is as far as it goes! The NM is/was supposed to be in charge of our resources. Ancillaries are great but have little support from NM only their CNC's for the most.
- This is done and is not problematic.
- They are already.
- Not appropriate.
- Anything has to be better than centralised buying and ordering. The CNC at a facility would be able to consult with their staff as to what products they think should be used and their experiences in the use of those products, rather than being told by someone that this is what you are going to have, like it or lump it.
- Good idea as long as clinical staff had input and CNC appreciated \$ and its flow/allocation and work with non nursing staff to achieve best results.
- Nil issues. Works in our department extremely well.
- Nil. Works in our department extremely well.
- They could then keep a better eye on things: this is currently done.
- They are on this campus and it works well.
- Waste of clinical knowledge/resource- possibly initially established in conjunction with them and potential updates but that's about it.
- Submissions for new equipment are done in consultation with CNC and NM.
- Do they have the time? They should have an overview and know what there is, but the hands on stuff should be some one else's responsibility and they keep the CNC informed.
- Too much time taken away from clinical area.
- Unnecessary non clinical duty
- I think this could easily be an administrative task and does not really require nursing skill to perform. We have an admin manager who undertakes these tasks, and managing the budget for these items is delegated to her.
- CNC's mostly responsible now. Budget restrictions on spending. Replacement of equipment always an issue.
- Would hopefully eliminate some problems, ie if one company can't deliver acceptable alternatives could be used. Most already do this.
- CNC needs to understand financial constraints of the dept.
- They would have more ideas as what the wards need.
- I like the idea as CNC is aware of what we need.
- I believe that this is currently happening and works well.
- Excuse me they already are!
- They are currently managed by the CN, the CNC does not have time.
- I don't think that CNC should be directly ordering equipment but they need to be aware of the ward spending.
- Not appropriate - this could be described as 'non nurse' work and could be easily managed by others in consultation with CNC.
- They are a non clinical task to manage the equipment and stores.

Responses up to 15 May 2006

- This happens, it adds to the budget responsibility for the unit;
- I think they should be focused on leadership issues not tasks.
- No, this is a duty that should be managed elsewhere. This needs to be a service provided to nurses so they can effectively care for their patients.
- This is a good idea, the CNC is able to keep track of requirements.
- This can be done by anyone as long as the CNC knows what is happening.
- I believe this takes the CNC away from the clinical area and there are ways of acquainting them with the costs of their unit without them having to waste valuable time ordering.
- Neutral. However if the organisation were large it makes sense to have a centralised store.
- They are. I don't believe we should be doing that as decisions usually have to be financial not what's best.
- Unnecessary use of a person skilled in other things.
- In principal this sounds a very good idea as it would allow for flexibility and innovation, however, it's been my experience that not many CNC's actually understand how to choose a product that is cost effective. It may lead to duplication of stock or stockpiling, and what controls would be applied to avoid a budget blowout? Also some companies have contracts to supply certain amounts of certain products, so there isn't necessarily the flexibility that one assumes in the system.
- I don't see this as a nursing responsibility. CNC's need to be updated and kept informed on equipment and stores and provide advice, but I don't think they need to manage equipment.



- CNC is responsible for the nursing budget and should have control. Non-nursing items should be handled by the Administration Officer, at least in the larger units.
- Already are.
- This would take up clinical time and dilutes the CNC role.
- Would have more of an idea of what is required for nursing and the wards, sometimes though some decisions about equipment have been made with budget in mind and not patient safety.
- Can be done by someone else.
- They wouldn't get much time to do anything else!! And they do to an extent. How about employing more staff in Engineering & Building so they wouldn't have to rush tasks and inevitably come back and do it all again?
- This would be a good thing.
- They are. It's time consuming at times particularly chasing up routine stores that are not available.
- They can be managed by auxiliary staff, with CNC overview, like monthly costing reports. If the CNC is on the ward ensuring practice is right, then staff will also use appropriate materials.
- What a waste of time and expertise. The CNC should work with others to establish a baseline etc for stock levels and equipment but once in place others should take over.
- None.
- Not an essential part of the job, could easily be a consultation role only for the CNC.
- In my work place that is a component of their role already. Takes them away from clinical consultation and staff support.
- The CNC doesn't have enough time for this as well as the job that they are doing.
- Better management of budget.
- Not enough time. More continuity and more say in what we can have.
- Some do already.
- Currently are.
- Good idea, they know what they need.

What are your views of the issues if equipment and stores were managed by non nursing staff?

CURRENT RESPONSES - 20 July 2006 to 8 December (See below for previous responses)

- OK if appropriate training was provided.
- They currently are. The importance of having things well stocked is not always understood by these staff, and the impact of running out of items after hours and on weekends creates lots of wasted time. Often the numbers of items for stocking is not reflective of need but financial budget. Maybe if need was addressed with the CNC and the non-nursing staff person we could come to a much better situation rather than being done in isolation. People are focused on getting their task done and don't think bigger picture.
- I believe this could be done once staff were trained and had an understanding.
- Not a problem if they were tied to that particular ward/area in some way and either liaised with the CNC/nursing staff or came under the CNC.
- Our ward ancillary current manages stores and equipment needs in conjunction with CNC, CN and it works quite well. This role requires lots of training, however.
- Have experienced this. Depending on the training and personalities (and sex) can work well or be a disaster - important that the person works in consultation with nursing staff - communication is very important.
- No understanding of quantities needed.
- Non nursing staff probably don't have as much knowledge regarding what equipment is needed as they don't work on the ward. Would be ok if these people were easily assessable.
- Their time is not as important as ours which is reflected by how many go home early or hide now. I need someone who is reliable and who recognises our needs.
- Good idea, in consultation with budget holder.
- Good idea.
- Great, as long as they were accountable to the clinical staff and not only financial managers.
- Would be feasible as long as good communication with clinical persons as to required needs for equipment and supplies.
- No good... no idea of implementation.
- Yes! Provided there wasn't an argument every time you wanted something!
- Lack of knowledge and understanding of the equipment uses are our requirements.
- Great, more time for clinical. Just need to make sure the system is in place that identifies what is needed and appropriate stock replenishment undertaken, eg even on weekends.



- I work closely with ancillary for ordering stores, and authorise final outcome. CNC needs to manage equipment to monitor correct usage.
- OK as long as they appreciated the need for new equipment or stores as to patient need.
- Equipment should be managed in a 'pool' and transferred to wards when needed, not hidden in NUM offices so that staff can't use items.
- Stock levels can be managed/ maintained by non nursing staff once appropriate levels have been identified.
- That's what we have now, it only gets done once a week which is not adequate.
- We have an equipment CN who would be better utilised in an education of equipment role rather than as a storeperson. I think that a store person could manage the bulk of the stores issues.

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- They are now and we never get stocks on time, always run out, never delivered, hospital stocks finally arrive. Our ward ancillary keeps us going. Nightmare over weekends at times and Monday morning when there is nothing there. Equipment pool has improved this.
- Needs to be done in collaboration so that the supplies used in the area are appropriate.
- In part some are now.
- Consistency for the area(s) would be good; equipment pool - maintenance & servicing.
- Not on, for reasons given in previous question. xx Anything has to be better than centralised buying and ordering. The CNC at a facility would be able to consult with their staff as to what products they think should be used and their experiences in the use of those products, rather than being told by someone that this is what you are going to have, like it or lump it.
- Too \$ focussed but OK if clinical staff liaised with. May have better knowledge of market availability/ access to reps/ bigger picture of needs across organisation.
- Unaware of volumes of products that could be required at short notice and may not be able to acquire at short notice.
- Depends on who this would be - need clarification before saying yes/no.
- No problem as long as they take direction for nursing staff re the need for equipment and it is not used as a cost saving measure.
- No problem after initial set up.
- Do not understand the specifics of what is required and often go for the cheapest and not effective.
- Fine - as long as they are trained, and are responsible and accountable to someone like the CNC.
- OK/ Good x 3 answers.
- No Problem as long as they consulted with nursing.
- Excellent idea as long as CNC has final approval.
- Wouldn't have the appreciation for why certain brands of products are used. More likely to save money than look at quality of products.
- There are some issues regarding the knowledge of what is essential and can't simply be put on back order.
- I feel that they would be unfamiliar with required equipment and its use to make the best choices.
- Able to re-stock and take audits but shouldn't be responsible for re-arranging imprests or choosing items to be on stock.
- No they have no idea as to what the wards need or how much they go through.
- No I don't like the idea of that.
- I think non-nurses have limited understanding of the complexities of medical material management. It is not just about cost.
- Great idea.
- They need to be overseen by nursing staff.
- At our hospital it is managed by our orderlies.
- Appropriate.
- They are and should remain.
- Non Nursing would not have a hands-on feel for the needs of the ward.

Responses up to 15 May 2006

- Not much impact.
- They could be trained to undertake.
- OK if they are willing to be advised and informed by nursing decisions and requirements.
- Fine as long as they know what they are doing!
- As long as they have good guidelines for this I don't perceive that there would be a problem.
- Can be done but there would need to be input from a nurse as the non - nurse does not have the same knowledge or understanding of the equipment.
- Getting better! It would need some nursing input though - just to explain some of nursing's peculiar needs!
- Do it.



- They are in this unit in conjunction with the staff who require the equipment and stores.
- In our hospital they already are, this leads to some conflict when nurses want to try new products or stop using existing ones.
- I have no problems with this, provided there are adequate communication pathways to a senior nurse in work areas.
- It is difficult to manage equipment and stores if you are unaware of the usefulness of what you are ordering, ie you have to know how it is clinically relevant. Also, clinical practice changes so frequently that a nurse is best positioned to make decisions about appropriateness of equipment and stores in meeting the patient needs.
- Could be done in consultation, our practice is to use clerical staff for most things and an RPN for clinical and medical supplies.
- Depends, they might know what is required for the rest of the hospital, as long as they have an understanding of what is required and how urgent it is.
- Fine by me.
- In consultation with CNC. Why not the Nurse Manager? They're responsible for "human and material" resources.
- This could work as well.
- This would be OK as long as they had an understanding of the use of items and how important it is they are available.
- The CNC needs to have input into stock numbers etc, ie cannot be dictated to by non-clinical staff in the number of dressing etc they can have.
- This should be happening.
- None but would need intimate knowledge of the requirements especially in very technical areas such as ICCU and operating theatres. Would have to rely heavily on communicating with the staff using the equipment.
- No problems. It would be up to the nurses and equip person/department to work out a collaborative working agreement. It doesn't have to be a nurse to manage equipment.
- Under the authority or agreement of the CNC.
- People not using the equipment could be ordering it without an understanding of it.
- Interesting proposal.
- Really difficult to do as non clinical staff do not understand the use of the equipment and therefore they cannot assess its relevance.
- Yes in consultation with the CNC, someone else can shop around, then more time for CNC to do clinical work.

Do you have any examples of new nursing roles that have been developed in your area in the last year or so? If so, can you briefly describe them and the benefits and/or problems?

CURRENT RESPONSES - 20 July 2006 to 8 December 2006 (See below for previous responses)

- Aged Care Advocate - beneficial Wound Care Advisor – Beneficial.
- Additional Level 2 (CN) position developed - does not include clinical support, seems to be a "computer" position, presence in clinical area non-existent.
- We are prevented from developing any new nursing roles we would like to implement a discharge liaison nurse.
- Nursing handover to GP's in a shared care model. GP's accepting more responsibility and feeling better supported nurses feeling more valued clients having a better relationship with their GP and having more 'normalised' care and support.
- Resource Role of different areas with in the unit. Mentor for younger less experienced staff.
- Have just employed a CN for the first time. It is good to have the support and to have someone else to take a bit of responsibility and discuss things with.
- Catheterization of male patients - the Drs refuse to do the older boys even though it was agreed when we took on the role that they would catheterize over 5 year olds.
- Can't even sustain the old roles.
- PNA's are trained to perform more nursing duties and have been working well in this area (one only).
- Admissions/Discharge coordinator- much better patient flow, early discharge planning with necessary community supports.
- Nothing new has happened here in years.
- PNA's: love them. Love that they get an earlier intro to nursing and don't come out hating it during their GNP. Think that we should have TEN's employed after 6mths of their training in the same role as the PNA.
- We are about to have our own clinical learning coordinator for GNPs within the OR. We expect this to have a major impact on the educational opportunities for our GNPs and assist with recruitment and retention of GNPs to the area.



15 May 2006 to 20 July 2006

- Not yet but I have been told by my Level 4 that this CNC will be working very closely with me but when I asked if I could speak to this person from another hospital interstate, was told no. She and the project nurse had it in hand.
- Nurse practitioners. A range of different co-ordinating roles eg D/C planning, diabetic educator.
- Dedicated nurse educator in ED.
- PICC Inserters: RNs being trained and reclassified as a level 2, to insert PICC lines, and Doctors are happy with this. PICC carers: look after PICCs and any problems on wards. Problem is ward nurses lose skills with PICC lines and dressings and general maintenance and trouble shooting.
- NM managing allied health HR. Allied health are working seven day rosters, Team leaders who multi classed are too busy to manage the HR component of their role. Nurse Practitioner candidates.
- Developing nursing mental state assessments via videoconferencing of consumers in remote hospitals in country SA. Currently undertaking an accreditation process for this. Benefit will be 24 hour access by country staff to expertise in mental state assessment and in role modelling these skills.
- Sleep lab nurse, sleep lab now away from ward support therefore have needed to employ nurse for patient care needs. Previously relied on ward staff to attend when nursing duties required. Inpatients and Outpatients attend lab and have variety of co-morbidities. Nurse also has some technical role in application of monitoring leads and history taking etc.
- Nurse Practitioner roles and extended practice nurses.
- Nurse Practitioners, provide additional care to patients, improve access to patients, prevent admissions to hospital, link patients into community programs, improve communication and collaboration with primary care providers, support and teach nursing staff particularly about complex clinical issues.
- A level 2 position who works only early shifts and acts as team leader each morning However the R.N tends to pass on some of her tasks to other RNs to perform Plus this permanent position does not give junior R.N experience to manage the ward during the week.

Responses up to 15 May 2006

- Breast health nurse: this role has had a great influence on the health service provided to patients. this nurse has their own outpatient clinics and has instigated with medical and radiology staff a clinic for women with breast changes requiring investigation. This has resulted in an improved service to patients, cutting down the time and associated anxiety from 2-3 weeks to 3-4 hours.
- Ortho liaison nurse providing a consultancy and assessment function for newly diagnosed fractured NOF patients set up to improve the outcomes - new position, no problems as yet.
- Nurse led clinics in pre anaesthetic clinic - identified set of patients have their pre anaesthetic assessment performed by a nurse rather than an anaesthetist. Has taken a great deal of time to work with the anaesthetists.
- Respecting patient choices which is so very important and very successful.
- I have noticed in the organisation where I work a sudden increase in RN level 2 'project nurses'; From my perspective they seem to do a lot of admin work! Is this appropriate or do we need more admin staff?
- In the country anything that comes out and needs implementation usually gets left to the level 3.
- Project nurse roles.
- Escort nurse to facilitate the outside appointments for Forensic patients.
- Nurse practitioner: value added for the whole treating team. Provides holistic and timely interventions for the patients. Provides good feedback about nursing care of patients also.
- Clozapine Clinic/GP liaison, it has taken over two years to set this up and is still not completed. We lose interested nurses when it takes two years. They are in demand and won't wait.
- Regional Staff Development Coordinator- last 2 years. Regional employee working across multi-sites in large country region. Coordinates education across all work disciplines. Reports to HR and is closely involved with workforce planning etc.
- Nurses who work for general medicine but in ED, starting the "pull" from ED to ensure they get to a ward faster, with much of the initial assessment completed. Good concept, but poorly funded.
- Clinical Facilitator RN2 for Graduate Nurses, temporary appointment to work with newly graduated nurses in the clinical setting for the first month of their program: provided much needed support, assisting ward staff and also providing opportunity for RN to take on role. Clinical Facilitator RN2 for ANRTP students also temporary, to work with overseas Registered Nurses seeking Aust registration. Very different needs to other students. Provides support to students, assists ward staff with issues, liaises with Uni. Individual assumed responsibility for group and consistent approach to documentation and assessment. Problems identified and acted on early. Clinical Tutor RN2 for Bachelor of Nursing Students ongoing for 1 year to work on wards alongside students as well as provide clinical teaching.
- Midwifery led discharge midwifery discharge letter more timely discharge less work on the Doctor.
- Nurse Practitioner respiratory - requires succession planning.
- Respiratory Nurse Practitioner. Consistency of care, nursing input into care plans and consideration of the whole picture of the patient not just the lungs.



What do you think should be the main roles of the CNC (or CNM)?

CURRENT RESPONSES - 20 July 2006 to 8 December 2006 (See below for previous responses)

- Either management or clinical or equal mix of both.
- Clinical focus. Role model to staff, assist with complex issues, resource to staff, ensure the best for the patient by directing the care provided.
- Setting and maintaining clinical standards Reviewing customer service (patients, family, medicos, allied health professional) Understanding, disseminating, implementing and evaluating organisational policy.
- Clinical management of the unit, and development of staff rosters (or delegate/share this role with CN). Leadership and mentorship of staff to encourage their development.
- Leadership, vision and inspiration, encouragement, education, promote profession to the public, stand up for nurses.
- Clinical expertise available to support and guide junior staff, lead by example, advocate for patients.
- To oversee the ward. To have input into admissions and discharging of patients, rosters, any general problems that are occurring on the ward, To help out with patient care if needed, to try to ensure that nursing staff are happy and satisfied with working conditions and to try to help if they are not.
- Mostly managerial.
- To lead by example. Be available with difficult patient care to assist with appropriate action. help on ward during surge times. Update policy and procedure manual based on evidence.
- To provide advice, education for staff, support and guidance. To increase team work. Jack of all trades.
- I am confused about the difference between CNCs and Nurse Managers.
- Supervision/advocate.
- Overseer, resource person, someone who reads current literature to keep up to date, consultant for different decisions.
- Manage unit to be seen on the ward giving leadership and support and not in the office or at meetings.
- Clinical expertise and advice, clinical excellence, research clinical nursing.
- Oversee management issues, budget meetings, organise leave of staff (A/L & LSL + study leave).
- NOT CNM CNC: advanced practice clinical supervision/mentoring consultation & liaison education.
- Overseeing clinical work on the floor.
- Clinical expertise in area of work and delivery of same in conjunction with team members.
- Expert clinical knowledge Teaching new staff Resource for all staff Maintain nursing standards Performance appraisals Ensure yearly updates Involved in research Have vision for future direction Rosters Have role in recruitment and retention.
- Supervising, developing, supporting clinical work.
- Overall patient care, protocols, nursing rounds, education, staff management & RN/CN appraisals, running the ward, liaising with other departments, recruitment & retention liaising with Uni's, appraisals of students (this is getting bigger and bigger and taking huge amount of time).
- Administrative and clinical management of the unit (HR, performance management etc). Not be rostered to patient care each day as they need the time to "manage". Support the CN's to coordinate the ward on a day to day basis, provide leadership, role modelling etc.
- Hands on nursing, with a focus on mentoring/educating staff.
- Co-ordinating of the clinical management of the ward ie up to date clinical protocols / pathways.
- To manage the ward and not have to attend so many meetings out of the wards during the busiest times, after all they are counted in our numbers even though they don't have a patient load.

15 May 2006 to 20 July 2006

- CLINICAL!!! Patient care! Some committee work to look at protocols and new developments.
- Expert clinical nursing skill and knowledge effective communication skill good people management skill budgeting in conjunction with NM Education. Leader within unit, division and hospital.
- Clinical management, setting nursing standards, performance appraisal, QM, oversight of clinical education, selection of staff with the NM.
- Clearly the expert clinician not a manager of material or personnel resources.
- Staff management including hiring, rostering, performance management -leading unit based education and research -advocating for patients within unit -liaising with peers to provide best care across institution by sharing knowledge, sharing/rotating staff and supporting them to do so.
- We don't have them.
- Clinical oversight and advice to staff and organisations.



- Clinical expertise, performance management, strategic plan with CN's, education.
- Overall co-ordination of the unit for which they are responsible, safety, clinical supervision, quality improvement activities, program development and planning policy development, performance appraisals and management. Ongoing training and education that is unit specific research should include some hands on clinical work to keep up to date.
- Providing support to all staff education leadership conflict resolution preceptorship role model.
- CNC as the name implies a Consultant Nurse not an administrator.
- Mentoring and directing staff with patient care.
- Education, clinical focus, develop unit philosophy/program.
- Senior clinical advice re care of patients.
- Discharge planning. Conflict resolution. Co-ordination of ward/ unit nursing services. Incident management.
- Clinical teaching. Staff appraisal. Ward Management.
- Ensuring nursing practices, protocols and equipment are current. Providing guidance to staff for complex clinical problems. Educating new staff. Research. Rosters Overseeing clinical nursing staff.
- No ward office. Team Leader work. Just run the ward on the ward and not off the ward at meetings all the time. Maybe do one shift on the morning as an RN just to remind them of the work load on the ward.
- Day to day management of the clinical environment; supervision of staff in the clinical environment; monitoring of clinical performance indicators; act as a best practice clinician.
- clinical teaching, support of staff, represent ward/unit at hospital meetings, auditing of clinical care and providing feedback to staff.
- Some clinical component needs to be included.
- Supporting junior staff and supporting R.N with the clinical management of clients.
- Clinical expert with appropriate knowledge, skills, attitude and experience to clinically manage and provide guidance to less experienced nurses.
- To manage the staff who have professional responsibility and accountability to conduct the best possible patient care.
- Overseeing the clinical care of the ward.

Responses up to 15 May 2006

- Total management of a unit.
- Leadership, advocacy, resource, clinical leadership.
- To manage clinical specialities. I think they should case manage as consultants and be accountable for these patient's care.
- To oversee the clinical management of a determined area. Ie manage the patient group and staff group. Ensure quality of care through QI activities, education for staff. Should be an expert clinician in the area and have sound leadership skills to enable them to lead the group.
- Clinical management and on the floor and visibility.
- To set standards for the nursing care delivered. To ensure that all staff are able to adhere to these standards - assess staff capabilities, provide education and instruction if so needed.
- Expert clinician and leader of a team of clinicians.
- Certainly the role as it is becoming more managerial There is not such an emphasis on expert clinical knowledge unless you take into account nurse practitioners. If the structure is going to look different it would be interesting to see how this role would look. People need someone to be 'in charge' at a local level - whatever the geographical layout of the place looks like. It does not necessarily need to be a level 3 - it depends on their level of responsibility.
- CNC clinical management CNM some clinical management, organising the nurses (not everything else someone dreams up that needs implementing).
- The clinical expertise of most CNCs is completely wasted in many units. They spend time at meetings and undertaking administrative tasks. The main role should be sharing their clinical expertise with those delivering care. Maintaining the functioning of the health care team - communication, coordination etc.
- I'd love to not have a patient load 5 days per week. I'd then have the freedom to spend one of these days on the ward working with new or junior staff, doing hands on teaching. I'd also be able to negotiate to swap some days with Level 1's to allow me to cover their shift whilst they attended meetings, study days, went to see operations etc. At present I'm 'non clinical' 3 days per week, but I give one of these over to my CN's. I think teaching is important because we tend to drain experience away from the clinical area. After that, developing a vision for the ward and driving through change. Looking at new products and new ways of working. Enabling staff to bring forward ideas and looking at how these can be implemented, working with other specialists to raise standards, developing protocols relevant to my field of practice.
- Advocacy - staff and patient. Effective communication. Delegation and work allocation in consultation with CNs. Team building, risk management, Clinical policy.
- Clinical Management. In my areas the roles seem appropriate.



- Education specific to the area, clinical support, exemplar, guidance to less experienced staff, clinical audits.
- Ward working functions, protocols, staff management/development, leadership.
- Clinical support, expertise and resource for staff.
- Responsible for the standards of care and striving to improve the standards of care. Provide a strong clinical role model. Mentor CN's; Resource for staff - nursing & others.
- Ensure right equipment that functions. Some specialty education. Tutorials and education packages. Liaise with other health professionals. Ensure things run smoothly at ward level.
- Staff education and support, expert knowledge in patient care. Involvement with families, discharge planning, ensuring good patient care, input into medical decision making etc. Policy and standards preparation and review.
- Mentorship, expert knowledge provider, role model, educator, orientor. Patient assessor of all things to ensure dots are being joined, so care and treatment is gap free (overseer or case manager) Assessor of nurses performance.
- To assist others with clinical decision making and patient assessment, team builder and maintainer, educator, role model.
- Clinical management of the unit. Resource for staff. Monitoring practice against benchmarks.
- Clinical focus, staff skills and practice, issues related to the clinical arena, evidence based practice, standards of care, clinical leadership, patient safety. The realm of clinical practice that surrounds the delivery of safe and high quality nursing care and supports those who deliver it at the coal face.
- Clinical consultation for staffing coordination and mix of the immediate area, consultation of nursing care, research and evidence development, lead policy and procedure, audit development and practice, leadership of clinical team and support resource to facilitate client and staff needs, occupational health and safety identification and evaluation.
- Support clinical staff but to also have some clinical duties to maintain skills and an understanding of how the clinical staff work.
- Support the staff, liaison through level 4 and level 2, understand the ward capacity, complaints, budget.
- Clinical focus on patients, standards of care and supporting/educating staff.
- Clinical expert, care planning, role modelling, education, policy development, orientation.
- Maintain high standard of care. Ensure competent staff. Undertake research. Facilitate professional development of staff. Staff performance review.

What do you think should be the main roles of Nurse Managers?

CURRENT RESPONSES - 20 July 2006 to 8 December (See below for previous responses)

- Management.
- Supporting the clinical setting with appropriate rostering that meets the needs of the the unit. HR. Managing equipment.
- I note people put assisting the CNC - does that mean to relegate them to a CN level? I see no role for an NM as they are second class citizens. Give the CNC an Administrative Officer ASO5, and together they can manage both administrative and clinical work.
- Support of the organisational side of running the ward.
- Support clinical areas by sourcing additional staff such as agency or relievers as determined necessary BY THE CLINICAL UNIT.
- Supervise skill mix, make sure staff have current efficient equipment and protocols.
- Rosters, stores, HR, acquisition of equipment, advocate for staff requirements on the ward, bed management.
- Budgets, Major problems on the ward, rosters, to help out with patients if needed (very unlikely), give nursing staff feedback on their work. To ask for nursing staff input into the running of the ward.
- Consultants.
- Oversee daily operations. Plan appropriate staffing levels. Support evidence based practice. Support staff in continuing education. Not to show favouritism to staff.
- To provide advice, education for staff, support and guidance. To increase team work. Jack of all trades.
- I am confused about the difference between CNCs and Nurse Managers.
- Control and set standards of work place - maintain up to date policies and procedures.
- Managing paper trail. the 'go-to' person for advice on clinical issues.
- Organising hospital activities that don't relate directly to nursing at the bedside. Running the hospital.
- Support in all aspects as required. Background admin support in the network.
- Unsure.
- As for CNC plus organise worker issues and give leadership.



- Overall management of staffing.
- Overall management of facilities or sub-sections there-of.
- Resource management: Human and material.
- The financial and staffing requirements.
- Not sure.
- Recruitment and retention. Develop/agree on nursing standards with CNC. Human resource activities. Ensure adequate skill mix available. May manage more than one ward. Resource/support for CNC.
- To make sure what is needed to undertake clinical work is available and used.
- Recruitment/retention in a larger scale. OH&S interviews. Rostering/staffing/annual leave. Bed management.
- Administrative management.
- HR and rostering in conjunction with ALL staff in the unit.
- Management of the different areas and ensuring that appropriate systems have been put in place to enable organization to run.
- To manage the service, bed management, staffing but not rosters.

15 May 2006 to 20 July 2006

- Rosters/holidays which have been done badly for years in our area. Resources that we all need? Never done. See staff more often. be fairer; audits re equipment.
- Effective communication skills, good people management skills, rostering and budgeting in conjunction with CNC.
- HR management, rosters, selection of staff, producing data, re staffing, assisting with resource management.
- Material or personnel resources.
- Working with/supporting the CNC -having the bigger picture view in trouble shooting issues to achieve the best results for all without favour -seeking knowledge from outside the institution to support / assist in altering current practices -coordinating and liaising with others in implementing activities rather than usurping the CNC and exerting own will!
- Budgets, rosters and complaints.
- Managing organisational issues that relate to nurses.
- HR responsibilities, bed management, resource management, budgets, recruitment and selection, performance management, WorkCover.
- Work with CNC's for managing staff plan HR support to nursing staff annual leave planning budget compliance policy and quality activities.
- Rosters, HR resource.
- The administration associated with rostering leave HR etc but this could be done by a non nurse (heresy I hear you cry).
- Support and advice to CNC's in their role. Training for staff in preparing to undertake CNC role. I do not think there should be a line management relationship with "nurse managers" this should occur through service directors.
- Supporters of ward staff, rostering, leave entitlements. Payroll, resolution of disputes. Performance review.
- Administrative.
- Managing staff complaints/issues. Auditing nursing performance. Financial management of department.
- To hire and fire staff, ensure CNC have right info at their finger tips.
- HR management of nurses; recruitment & retention of nurses; rostering of nursing staff; monitoring of clinical performance indicators.
- Managing staff complaints/issues. Auditing nursing performance. Financial management of dept.
- To hire and fire staff, ensure CNCs have right info at their finger tips.
- HR management of nurses; recruitment & retention of nurses; rostering of nursing staff; monitoring of clinical performance indicators.
- Rosters, budgets, Workcover, equipment.
- All ward administration.
- Managerial expert with appropriate knowledge, skills, attitude and experience to provide managerial support to the clinical area.
- Oversee all the units/wards.
- Attending to quality management and accreditation.

Responses up to 15 May 2006

- To assist in the management as requested by the CNC.
- Management of the unit on a day to day basis - administrative tasks Close working relationship with CNC.
- The HR functions associated with nursing.
- HR activities, quality activities around management practices. Recruitment, bed management. strategic planning for HR needs. Occ health and safety, Work Cover input.



- Rosters and booking leave, audits etc.
- To ensure that staff are enabled to deliver a high standard of care - enough suitably qualified staff available through rostering practices, education possibilities etc.
- Management, people and resources but inclusion in the clinical sphere so that work they do reflects the needs of the clinical area.
- Relegated to the bowels of the earth to dig forever! They have earned themselves a bad reputation. They have been the roster masters and have wielded great power and caused much misery - delete the role - it is a haven for petty tyrants!
- Depends on size of unit in the country. A nurse manger should manage nurse and their education.
- Nurse Managers presently undertake HR roles that might better be done by HR managers. Nurse Manager needs to supervise those who contribute to nursing. e.g. stores, HR managers.
- Assuming you mean L4 and L5 - to provide me with the means and encouragement to achieve my goals.
- Management of ward activities in consultation with CNC and other nursing staff. Evaluation. Clinical governance Policy development.
- Rosters, personal issues, coordinate issues for the areas etc.
- HR issues, Finance and Rostering.
- Support the clinical activities thru' managing human & material resources.
- Budgets, staff employment ,setting up of Dr templates, chasing up changes. Ensuring enough stock. Liaise with admin and report. Deal with complaints. Assist with the development of the area. Assist with surveys. Do EQUIP and risk management. Do the fire warden and OH&S training. Carry out audits. Do the computing side. Monitor the amount of throughput in outpatient areas. Organising education programs and mandatory updates.
- Stores, staffing issues, employment, non clinical/staffing issues.
- Human resource management.
- Management of the human component of staffing. recruitment, retention, Workcover, annual leave, awards, pay. Represents unit on hospital non clinical board/committees etc.
- They are the 2nd poor cousin to the educator, maligned and under valued. Managers should be well supported by corporate services, educated in their current role demands and not necessarily nurses. A waste of nursing education and skill.
- Support the Level 3, clinical rosters.
- Recruitment, rostering, supporting staff.
- Human resource management.
- Budget and finance, Recruitment and retention of staff, Staffing levels, Skilled staff, Occupational health and safety of patients and staff.

What do you think should be the main roles of Nurse Educators?

CURRENT RESPONSES - 20 July 2006 to 8 December 2006 (See below for previous responses)

- Facilitating staff education.
- Providing appropriate education to ensure that staff are able to provide appropriate care to the patients. Liaising with CNCs, CNs, NMs, NDs re the needs of the clinical settings. Being a resource and an adjunct to the workplace. The role of Clinical educators would also be supportive to the CNC with new staff during induction or staff that are struggling with capabilities, it is important that their role is recognised and that they are not considered "another pair of hands" by the clinicians.
- Support the staff to gain the clinical/academic/organisational skills that they require to improve patient outcomes.
- Development of education programs, clinical education.
- Students and new grads.
- Support and encourage all levels of staff with the acquisition of skills and knowledge, resource for information about further study(both informal and formal courses), staff development, teaching within knowledge base, development of quality practices and documentation of these, maintain and facilitate mandatory requirements, audit performance and identify skill deficits create staff development activities to address any deficits.
- Ask nurses for their input into what education they need and to provide that education. Make themselves easily accessible and known to the nursing staff.
- To provide educational pathways to staff including frequent in service education.
- To provide education to staff. Support staff in education. Provide opportunity for staff to do research projects.
- To provide updated knowledge to staff and updated protocols.
- Student support, professional development, education packages.
- A person to seek guidance and information re any role undertaken as a nurse in the workplace. To provide answers and info.



- Holistic patient care without being pressured by time constraints, other duties. Challenging management decisions that are only financially based.
- Education??
- Keep nurses up to date on new issues and methods, provide new training and revision, encourage further study, encourage career moves.
- Feet on the ground.
- Education, both clinical and theoretical, provision of expert advice, involvement at clinical level.
- Encourage nurse education, in-service, health promotion, updates, facilitate student learning.
- Education research clinical supervision clinical mentoring.
- Clinical teaching in the classroom and in the work areas.
- To have relevant up to date clinical experience which they can impart to junior members of team.
- Educate staff on procedures and standards Keep up to date with changes in practice and inform ward staff Act as clinical resource Active in continuing profession education Review procedures.
- To educate nurses.
- Firstly we need local nurse educators. This would relieve the CNC greatly. Orientation of new staff, daily education sessions training/assessment of ward based skills teaching students what they haven't learned at Uni.
- Provide academic education support units. Also need to have "clinical educators" as well as those who work in education centres. The clinical educators need to be available at unit level to support staff, especially those working in special and intensive care areas.
- Hands on role teaching, not just uni based. Bring back hospital training for nurses.
- Developing and maintaining staff skills, running orientation programs and GNP programs, but also being live in the wards not just hidden in an office. Nurse Educators need to work in the real world at least 1 shift a week to see the changes that are happening, and where training needs analysis needs to happen.
- Education and support all staff, maintaining of up to date skills.
- To help with changes to procedures, update our skills, work with us on the wards.

15 May 2006 to 20 July 2006

- EDUCATE AGAIN!!! Teach the important stuff that a new nurse wants to know on the wards. They don't need to see the chaplains etc. Teach all the annual updates. Go through the workings of the hospital wards; med. chart, DDA, documentation etc.
- Excellent clinical knowledge in an area. Education of the staff in that area.
- Co-ordination of structured programs Clinical educators at ward level essential, in each ward, to assist with orientation, clinical education and assisting CNC with clinical challenges, and assisting with the co-ordination of the ward in-service.
- This role has become non-effectual in the clinical areas. They have been centralised & generalised. Need to consider areas specific across the level of skill of nurses. That is, EN's, GN's & above L1 RN's.
- Working with CNC to implement pertinent and timely education, report individual staff difficulties in a non judgemental way -working with staff to assess their level of need and provide education suitable for their needs / at appropriate level -seeking new and innovative ways to share knowledge -maintaining own clinical skills -being up to date with current practices and new innovations.
- Educate in specific fields. Also overview of procedure manuals and protocols specific to their area.
- Co-ordination of structured programs Clinical educators at ward level essential, in each ward, to assist with orientation. Clinical education and assisting CNC with clinical challenges, and assisting with the co-ordination of the ward in-service.
- This role has become non-effectual in the clinical areas. They have been centralised & generalised. Need to consider areas specific across the level of skill of nurses. That is, EN's GN's & above L1 RN's.
- Working with CNC to implement pertinent and timely education, report individual staff' difficulties in a non judgemental way -working with staff to assess their level of need and provide education suitable for their needs / at appropriate level -seeking new and innovative ways to share knowledge -maintaining own clinical skills -being up to date with current practices and new innovations.
- Educate in specific fields. Also overview of procedure manuals and protocols specific to their area.
- We don't have them.
- To provide education.
- To educate and support nurses (around education, new skills , up to date practices etc)at all levels.
- To provide education to all staff with in their area.
- To educate! Surveys of training needs and a program based on this. Updates for mandatory skills, remedial training and support skills, development hands on training in units - take it to where the staff are and deliver unit



specific training specific skills development - eg specialist therapies and approaches should involve some hands on clinical work from time to time to keep up to date with issues and practice.

- Education of new nurses, providing staff development.
- Clinical education and practice development.
- Broad range of education opportunities for nursing staff/students. Important to be in touch with current learning needs.
- Support of all levels of staff. Assessment of knowledge needs of areas and delivering particular learning packages to up skill areas to have specialty knowledge of their working area. Provide during overlap time mandatory updates on wards.
- Organising and promoting study days/events. Providing additional help to junior staff. Research.
- To be on the ward and work with new staff, graduates and to be there to help with questions etc.
- Provide educational support to clinical staff; act as a resource for best practice models.
- They need to be more clinically focussed, many have not worked in the clinical area for a long time and lack credibility.
- Developing education for nursing staff within their ward areas.
- Educational expert with appropriate knowledge, skills, attitude and experience to provide educational support to the clinical area.
- To educate all the nurses in the organisation.
- Educating all nursing staff.

Responses up to 15 May 2006

- Assist the CNC to provide updates/education sessions.
- Students Competencies. Trialling new products. Education of staff.
- Facilitating and providing opportunities for further professional development of nurses.
- Education of all staff new and old. should range from 1;1 to group sessions, in the classroom as well as the bedside-more visible and more of them.
- Provide education to all levels of staff to ensure that nursing care is maintained at a high standard.
- Education of nurses but with a more pivotal role in the clinical areas not all in the Education Division but at the bedside.
- There could be a variety of nurse educators - those who work closely in the clinical field and those who look at and deliver 'bigger picture' education. The levels of education are: Inservice education - keeping up to date Clinical supervision particularly in specialist areas Annual updates (groan) Nationally accredited courses - certain courses that would not be attractive to some mainstream education organisations Specifically tailored courses that may or may not be accredited.
- What are they??
- Nurse Educators undertake the role of clinical specialists because clinical specialists don't have the time. CNC, CNMs and Nurse Educators should be interchangeable to provide education for all those in the health care system.
- Providing and supporting education. Representation on committees as required and a minimum number of clinical shifts per month so that they remain clinically relevant.
- Development of educational pathways for nursing staff. Identification of staff knowledge, skills and opportunities for advancement, Professional development. Evaluation.
- None in my area.
- Providing resources for staff for further education promoting best practice.
- Clinical support, role modelling, orientating new graduates/re-entry staff. Coordinating orientation. Updating staff on new approaches. Conducting research and audits. Should tie in more closely to Staff Development more generally- not operate in isolation as they are members of a much broader health service (multi-D-input).
- Induction & Orientation of new staff; manage in-service programme; Assist CNC with staff who are struggling clinically.
- General education, mentoring, helping new nurses.
- There is a big scope for educators but we have so few that they have no input into our area. The question is too big to answer. However I believe every acute area should have a person who has time allocated each week for education.
- Work with brand new nurses in the patient care areas. Running of competency courses and assessment. To provide education when it is needed and where it is needed. To assist CNCs with team building/leadership development/ to be a neutral party and sounding board. Role model/motivator/facilitator/agitator/advocate.
- Professional development of all staff. Design, develop & deliver in-house programs. In-service education. Research.
- Evidence based practice, needs analysis of educational needs of unit, facilitating those needs and evaluating them in terms of value to the nurse, unit needs and patient outcomes. Larger picture of the journey of the nurse through the skills of the area, identify needs of unit versus needs of staff for professional development. Also



career planning, what courses to do/are available, how to plan to get from point A to point B gaining skills in a proactive way to prepare for promotion. Clinical nurse educator may have some or all teaching at bedside and teaching clinical skills/ lecturing/ development, workbooks etc.

- This is the poor cousin! Misunderstood, under utilised in areas of education consultation, clinical settings have separated education from clinical teaching. Big mistake! A valuable commodity their role needs to be integral to any service, consultant of methods of education delivery and content of education to clinicians, lead in role modelling, learning as a life long endeavour. Consult for and implement hands on education/ skills learning, clinical teaching, teaching how to teach, feedback. Be a significant part of research, clinical based projects. Work closely with Directors, CNC, CN, staff and other educators.
- Provide clinical education on the wards. Be available for supervision of more junior staff.
- Help support students, refreshers re entry and new staff off site education.
- Education.
- Education ON the wards in relevant topics to the areas.
- Staff professional development. Looking after the graduates.

What do you think should be the main roles of Clinical Nurses (Level 2 positions)?

CURRENT RESPONSES - 20 July 2006 to 8 December 2006 (See below for previous responses)

- Overseeing the hands on care of patients.
- EITHER Support in clinical area OR Research/projects OR Advanced practitioner OR a combination of the above
- Assisting the CNC, role models to other staff, precepting new staff. The role of the CN has not fulfilled the intent of this role. The CN often has a full workload so teaching and support to the CNC is compromised. Time needs to be factored in to allow the CN to fulfil their role.
- Have an area of expertise, teach other staff re speciality, responsible for documentation, stocking, promoting, community awareness.
- Expert knowledge/clinical ability. Able to direct and provide excellent patient care. Good nursing model, understands and supports the CNC and organisational goals. Prepared to contribute to their wards/hospitals policy, procedural and educational development.
- Leadership, support CNC in managing unit, provision of education, and clinical expertise at the bedside, recognition of experience.
- Support and nurture junior staff, be available to be clinical expert in area, advocate for patients, identify skill and knowledge deficits and report to senior staff to develop strategies to address deficits, involved in information sharing across nursing levels.
- Administration.
- Assist on ward with difficult cases or in surge times. To be up to date with latest evidence based procedures and support staff in changing routines (old practice) to latest practice.
- Education, support, guidance. Support students. Frontline with nursing staff.
- To be able to be "in charge", responsible and accountable for running a shift, extra duties such as rostering, clinical knowledge resource to staff.
- A provider of education and updated knowledge to the workplace and nursing roles.
- Who are these?
- Unsure.
- Resource, keep up to date with current literature.
- To be professional, keep confidences (which they don't), to be a guide, to maintain a high standard.
- Provide clinical expertise at ward level, inspire clinicians, oversee implementation of clinical best practice with CNCs support.
- Ward management Skill mix & appropriate staffing levels Ensure D/C planning underway Assist in client care.
- Advanced practice clinical supervision/mentoring education.
- As the clinical expert on the work area.
- Broad knowledge and delivery of care to pts in the setting. Trouble shooting mentor resource person for ward staff.
- Clinical leader. Clinical resource teaching/precepting new staff. Clinical education of new staff. Relieving CNC Supporting CNC.
- Clinical specialist in area of employment.
- Support/education of all staff. Support CNC in her presence and absence. Identify ward based needs. Report to CNC. Assist with appraisals. Assist with rosters.



- Coordinate the unit on a shift by shift basis.
- Specific Clinical roles, with a additional focus on sharing skills with L1 staff.
- Works under the CNC in regard to setting up of protocols/pathways.
- Discharge planning, daytime bed management, but shouldn't do this if they have a pt load because one suffers.

15 May 2006 to 20 July 2006

- Assist the CNC. Develop their own skills and build on them. Bring in fresh ideas and help CNC co-ordinate staff to develop too. Handle clinical part of normal day, support CNC.
- Support of CNC role. Expert Clinician. Succession plan for CNC. Role Leader.
- Learning the management of the ward. Learning the role of the N/M. Role modelling. Clinical teaching on a shift by shift basis.
- Skilled & specialised to the area of appointment.
- Support the CNC -liaise between level 1 and ENs and CNC -support and assist with educators work as appropriate -mirror good behaviour, exemplary practice, be up to date clinically and 'politically' and promote the values of the unit, the institution, nursing and humanity.
- Clinical experts in their chosen field.
- Depends if they have more than one day a month off clinical duties, otherwise workloads can make it difficult.
- Shift coordinators.
- Provide shift or daily oversight of nurses working at Level 1 - take leadership role in their setting (ie team leader).
- Should do the daily operations of the unit and in collaboration with CNC and NM.
- Hands on management of the unit, in close collaboration and accountability to the CNC involvement in appraisal, policy development and service development activities hands on clinical work.
- Supporting the CNC, supporting nurses, ensuring patient safety and an overview of the ward.
- The expert clinician available on all shifts with some limited admin function however available to junior nurses for on the spot advice and help.
- Day to day clinical control of the unit. The first people the other nursing staff should seek to deal with minor dilemmas. They should not have case loads.
- Core staff, provide level of experience and help set culture for the units. Preceptorship of new nursing staff.
- Clinical support of RNs, ENs and Students. Coordinators of ward work/day to day running.
- Clinical education / staff appraisal.
- Providing guidance to staff for complex clinical problems. Educating new staff. Research.
- Organize staff on the day, ensure staff levels in each area is adequate, do a talk each month about something to do with the ward.
- Support CNC in clinical environment.
- Day to day coordination of ward, discharge planning, mentoring of staff.
- They could have more time to give to their teaching and development role.
- Hands on teaching and education of staff, supporting the clinical CNC, with education and client management.
- To be the clinical expert when the CNC is not present on the ward - not 'office hours Monday to Friday' due to budget constraints.
- To assist the CNC to manage the ward/unit. To be a role model to all nurses, health care professionals including allied health care professionals.
- Overseeing the hands on care of patients.

Responses up to 15 May 2006

- Provide support to CNC by taking on some of the role as required. Act as role models.
- Work shift work and support nurses after hours when CNC not available (7 day roster).
- Provide RNs and ENs with clinical support.
- Ward coordination of patient care, experts in the field, discharge planning, participation in quality activities, provision of leadership in the delivery of care support the CNC & NM in their work, support the ward staff in clinical decision making.
- Running shifts after hours and time given for projects and/or research.
- Ensure the maintenance of high nursing care standards by assisting the clinician, manager and the educator.
- Main roles are as experts in their field, role models for other staff and as the participants in succession planning for more senior roles.
- Depends on where they want to put their focus. This could be a good training ground for higher roles whether in clinical, management or education Gives them greater responsibility and some flexibility to try things out - I think even with the current structure it is a great role - I loved it!
- They are currently doing at least level 3 work in the country. They should be the clinical experts at ward level working with nurses and patients.
- Well I don't know if we need them. They are just part of a structure?



- Difficult because I see them as working so closely with the CNM. Supporting the CNM in implementing change, acting as a role model and a clinical leader, helping to define the future direction of the ward and work towards it, managing staff education, seeking ways to improve the working environment. Assessing and managing risk.
- Effective communication. Clinical Supervision of RNs and ENs. Provide expertise and support to RNs and ENs.
- Supervision of RPN and students. Act in role of CNC. Contribute nursing perspective to meetings and groups. Manage a complex case load.
- Helping with the CNC ward working functions.
- A support & resource to all ward staff, role model, support CNC and after hours CNC & NM, manage difficult clinical situations after hours then notify CNC, assist with performance management, relieve CNC supervising and hands on education of new staff.
- Education, assistance to CNC, policy writing review, involvement in medical decisions. Currently they are very limited in their role with no time to undertake special tasks unless they do it at home which is not appropriate.
- Primary support for day to day clinical functioning of the unit. Team leader Interface with medical teams in teamwork with the CNC especially when 3 teams are visiting at once. Mentor and support.
- Clinical expertise, ability to assist others with clinical decision making and patient care issues, educator, motivator.
- Clinical management of specifics relating to current portfolio. Clinical education of more junior staff. Succession planning.
- Interface between level 1 and 3. Advanced practitioners, novice educator and CNC type skills in teaching and evaluating care and outcomes, clinical support.
- Clinical nurses role is under utilised - role modelling, clinical support, active in leadership of clinical area along side CNC. Undertake clinical teaching, feedback performance, development with staff.
- Assist level 3 support level 1 and students.
- Run the ward, resource for level 1, take on a portfolio to take over a responsibility of the ward but need more management time.
- Representing CNC after hours, supporting new staff.
- Clinical experts, educators, role model.
- Help CNC and Nurse Manager. Coordinator of clinical area. Role model for junior staff. Ensure standards are adhered to. Orientation of new staff.

The next question refers to the 'Seven Guiding Principles for Future Nursing Care Delivery' proposed by The American Organisation of Nurse Executives.

Do you agree that these principles could apply in South Australia?				
Yes, very much	Yes, with some reservations	Possibly	Generally No	Unsure
24%	41%	14%	8%	13%

THANKS FOR PARTICIPATING