QUEENSLAND HEALTH

MINISTERIAL TASKFORCE nursing recruitment & retention

FINAL REPORT

SEPTEMBER 1999

TABLE OF CONTENTS | LINKS

Table of contents	2
Acknowledgements	4
Executive summary	5
Summary of recommendations	7
1.0 Introduction and background	12
2.0 Project management of the Ministerial Taskforce	14
Figure 1. *Project management of the Taskforce*	14
3.0 Data Collection	17
3.1 Determining the rigour of the study	17
3.2 Limitations of the study	18
3.3 Data collection tools	18
3.3.1 Nursing workforce data collection, Queensland Nursing Council registrations, and Queensland Tertiary Admissions Centre (QTAC) information	18
3.3.2 Structured telephone interview survey	19
3.3.3 Workshops/focus groups	
Table 1 *Nursing Representation — Corporate Approach Workshop*	20
Table 2 *Statewide workshops participation*	21
3.3.4 Surveys	23
3.3.5 *Invitation for Submissions* information to the Taskforce	23
3.3.6 Expert working groups	23
Figure 2 *Taskforce participation — location of submissions and focus groups*	24
4.0 Discussion and recommendations	25
4.1 To undertake a comprehensive review of the pre and post registration education, training and staff development needs of nurses to better match workforce planning needs.	25
4.1.1 Pre-registration education and training to better match workforce planning needs	26
4.1.2 Post registration education and training to better match workforce planning needs.	29
4.2 Develop guidelines for the management of nursing resources and workloads.	33
4.2.1 Recruitment of new graduates	34
4.2.2 Retention of new graduates in the Queensland Health workforce	35
4.2.3 Recruitment of the nursing workforce	36
4.2.4 Retention of the nursing workforce	37
4.2.5 Recruitment and retention of the nursing workforce	39
4.3 Promote the introduction of family friendly rostering and management practices.	45
4.4 Aged care	47
4.5 Mental health	48
4.6 Overarching recommendation	48
Bibliography	49
Appendices	
Appendix 1 – Data analysis and results	50
Appendix 2 – Proposed Nursing Advisory Unit	87
Appendix 3 – Queensland Health's nursing workforce – a framework	88
Appendix 4 – Expert working groups	90
Appendix 5 – Telephone interviews – DONs	92
Appendix 6 – Workshops	93

Appendix 7 – Focus groups process 94
Appendix 8 – QNC interview format For DONs 96
Appendix 9 – QNC focus group format for RNs 98
Appendix 10 – RN (first year graduate) questionnaire 101
Appendix 11 – Invitation to submit 105
Appendix 12 – Discussion paper – OPs 107
Appendix 13 – Annual turnover rate 109
Appendix 14 – Mental health report 110
Appendix 15 – QNC position statement 116
Appendix 16 – Aged care issues paper 119

Appendices tables and figures

Table A 1 *Workforce component* 50
Table A 2 *Average Age of Workforce* 52
Table A 3 *Comparison of first preferences for late entry and Year 12 applicants* 52
Table A 4 *Nursing turnover rate related to age group* 54
Table A 5 *Percentage of nursing turnover for years of service* 55
Table A 6 *Changing age profiles* 55
Table A 7 *Clinical placement workshop results* 58
Table A 8 *Category of nurse (n = 201)* 66
Table A 9 *Availability of mentor or support person (n = 201)* 67
Table A 10 *Appropriate use of skills (n = 201)* 68
Table A 11 *Skill acquisition and organisational support (n = 201)* 68
Table A 12 *Flexibility of working environment (n = 201)* 69
Table A 13 *Changes in rostering practices (n = 201)* 69
Table A 14 *Family friendly policies (n = 201)* 70
Table A 15 *Use of family friendly policies (n = 201)* 70
Table A 16 *Mechanism for staff comment (n = 201)* 71
Table A 17 *Mechanism for staff comment as satisfactory/effective (n = 201)* 71
Table A 18 *Staff input into clinical decision making — positive responses (n = 201)* 72
Table A 19 *Staff input into organisational decision making — positive responses (n = 201)* 72
Table A 20 *Career structure meets career objectives — positive responses (n = 201)* 73
Table A 21 *Type of health institutions in which the respondents in the study are currently employed* 73
Table A 22 *Type of Unit by length of stay in each unit* 74
Table A 23 *Benefits of the New Graduate Program* 75
Table A 24 *Non-beneficial components of the program* 75
Table A 25 *Key member of staff who oriented/integrated nurse into unit by participated in a formal new graduate program or no formal new graduate program* 76
Table A 26 *On average, the length of time before being given responsibility of a full client/patient load* 76
Table A 27 *How often was performance evaluated?* 77
Table A 28 *How often performance was evaluated by whether the nurse participated in a formal new graduate program* 77
Table A 29 *Further education presently being undertaken* 78

Figure A 1 *Geographic distribution of Queensland Health's nursing workforce (by District Health Service) September 1998* 51
Figure A 2 *Age distribution of Registered Nurse workforce, September 1998* 53
Figure A 3 *Age distribution of Enrolled Nurse workforce, September 1998* 53
Figure A 4 *Average annual District turnover rates for Queensland Health's nursing workforce (1994-1998)* 54
Figure A 5 *Best practice model of recruitment* 80
Figure A 6 *Clinical Education Pathway* 85
Figure A 7 *Age distribution of Queensland Health's aged care nursing workforce* 86
Figure A 8 *Proposed Nursing Advisory Unit* 87
Figure A 9 *Overview of the evaluation process in relation to overall supply strategy formulation* 89

ACKNOWLEDGEMENTS

The Steering Committee for the Ministerial Taskforce — Nursing Recruitment and Retention would like to acknowledge the contributions of the following:

- The members of the expert working groups formed for the Ministerial Taskforce (Appendix 4).
  - Best Practice Model for Recruitment
  - Corporate Approach to Nursing
  - Undergraduate/Graduate Transition Support
  - Supply
  - Flexible Working Environment
- Health Workforce Planning and Analysis Unit — Queensland Health
- Queensland Nursing Council (QNC)
- Queensland Nurses' Union (QNU)
- Workshop participants
  - Ministerial Taskforce
  - Nursing Recruitment and Retention.
- District Health Services / Hospitals that hosted Taskforce workshops
  - Weipa District Health Service
  - Cairns Base Hospital
  - Townsville General Hospital
  - Toowoomba Base Hospital
  - Mt Isa Base Hospital
  - Princess Alexandra Hospital
  - Gold Coast Hospital
  - Redcliffe Hospital
  - Gladstone Hospital
  - Longreach Hospital
- Queensland Health Marketing and Communications Unit
- University of Southern Queensland — Research Assistant, Nursing
- Contributors of submissions and information to expert working groups

EXECUTIVE SUMMARY

The Ministerial Taskforce, Nursing Recruitment and Retention was commissioned by the Honourable Wendy Edmond MLA, Minister for Health in August 1998 to review workforce issues and the recruitment and retention of nurses in Queensland. The Taskforce was implemented in accordance with Government Nursing Policy which stated: *There is a need for a review of the health workforce as difficulties in recruiting and retaining nurses have a fundamental impact on our health care system.* A Steering Committee was appointed and the inaugural meeting was held October 26, 1998 to consider the terms of reference and form a committee structure. Topic areas were developed by the Steering Committee from the terms of reference. The topic areas provided the basis for the formation of expert working groups. These groups were Corporate Approach to Nursing, Best Practice Model for Recruitment, Undergraduate/Graduate Transition Support, Supply Strategies, and the Flexible Work Environment. The Final Report was compiled by the Steering Committee with reference to the findings of the expert working groups, consultation and data collection from a range of other methods, and the Steering Committee's own deliberations.

Initially the Steering Committee reviewed Queensland Health workforce data. The employment of Registered and Enrolled Nurses in Queensland Health grew from 15,799 in December 1993 to 19,859 in September 1998, an average growth rate of 4.8 per cent per annum in full-time equivalents. The growth in nursing mirrored that of the total Queensland Health workforce for that time and can be attributed to the expansion of health services in response to demographic trends. In considering nursing turnover, the Steering Committee acknowledged that turnover is a complex issue. A formula to calculate turnover was agreed by the Steering Committee and applied for the Queensland Health context. The average turnover for nursing (Queensland Health) from December 1993 to September 1998 was 20.2 per cent for permanent nursing staff. The Steering Committee noted seven districts in rural and remote locations where turnover exceeded the average. The average length of service of nurses employed by Queensland Health rose from 4.8 years to 5.9 years.

Not withstanding general recruitment and retention success, this report found there was difficulty in recruiting and retaining nurses in a timely manner for many specific locations and particular areas of advanced skills. Significant problems for Level 3, 4 and 5 nurses were identified and seen to be potential barriers for effective future recruitment. Critical success factors for recruitment and retention of nurses were the need to support, promote, and develop nursing leadership in Queensland. The recruitment and retention of nursing staff for Queensland Health in rural, remote, and specialty areas such as cardiac services, aged care, paediatrics (including child and adolescent health) renal, mental health, critical care, midwifery, palliative care, oncology / haematology, emergency medicine, and peri-operative nursing is a continuing challenge. This is of particular importance for Queensland where fifty percent of the population resides outside the state capital. There has been deterioration in the national supply of nurses which is leading to shortages in Southern states. Currently Queensland is not fully

experiencing these effects. However, in the medium to long term the national supply shortages for nursing will have a negative impact for the state.

Further examination of workforce data demonstrated that the age profile of the regulated nursing workforce is moving upward at an increasing rate. Economic factors such as low interest rates and the age of the population in general restrict the retirement flows of nurses from the workforce. The years from 2002 to 2005 will be of most concern given the stability of current economic conditions, the age profile of nurses and the likely timing of expected national peak shortages. Also of concern nationally is the continuing reduction of the numbers of nurses below the age thirty. Data collected for this Taskforce indicate that the majority of nurses obtained post registration qualifications before this age. There has also been a significant drop of Year 12 students entering nursing pre-registration tertiary courses. Queensland is likely to follow the national nursing shortage trends unless there is active intervention of the type suggested in this report. The implications for Queensland of these trends include the potential for large numbers to leave nursing simultaneously. Resultant shortfalls in nursing numbers will prevent optimal succession planning, and growing shortages in specialist skills areas.

The recommendations in this report reflect strategies to deal with the current issues whilst ensuring effective risk management for the future. The urgency and importance of the recommendations have been indicated where appropriate. The Steering Committee recognises there would need to be a timely and staged approach to accepted recommendations progressed in accordance with government policy. We commend this report and the recommendations for your consideration.

SUMMARY OF RECOMMENDATIONS

The Ministerial Taskforce – Nursing Recruitment and Retention utilised current nursing workforce data and an extensive process of consultation to develop recommendations. The recommendations are:

Recommendation 1 *page 26*

That Queensland Health develops a process to facilitate work experience for and marketing to secondary school students and explores a collaborative approach with Education Queensland for advancing nursing as a career.

Recommendation 2 *page 27*

That Queensland Health examines the viability of establishing a scholarship system to support the employment of nurses to work in rural and remote areas.

Recommendation 3 *page 27*

That Queensland Health develops and implements a framework for a Nursing Career Advisory Service to:

- promote nursing as a career
- improve recruitment in nursing for Queensland Health
- develop the advisory service for undergraduates, new graduate and post graduate nurses
- act on the recommendations that relate to career advice from the Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN) report of August 1998
- incorporate the strategic direction of the *Queensland Health Indigenous Workforce Management Strategy*

Recommendation 4 *page 28*

That Queensland Health advocates to the Department of Employment Training and Youth Affairs (DETYA) and Queensland Universities that the current intake of 1200 undergraduate pre-registration nursing students be maintained for the next five years. This is in order to ensure 800 - 900 nursing graduates are available each year to meet projected medium to long term workforce demands.

Recommendation 5 *page 28*

That Queensland Health reiterates its commitment as a provider of clinical educational experience and allocates resources appropriately.

Recommendation 6 *page 29*

That Queensland Health establishes and resources a representative standing committee to facilitate the development of partnerships between the health and higher education sector to address ongoing issues.

Recommendation 7 *page 30*

That consistent with the Queensland Health Training Plan, the Health Advisory Unit (Nursing) coordinates the development of a training and development framework for nursing.

Recommendation 8 *page 30*

That a representative Standing Committee be developed between Queensland Health — Health Advisory Unit (Nursing) and the tertiary sector to match post graduate and enrolment courses to industry needs.

Recommendation 9 *page 30*

That the Health Advisory Unit (Nursing) initiates statewide education programs in the case where there are identified workforce requirements.

Recommendation 10 *page 31*

That there is development, implementation and evaluation of appropriate staff development management programs for all levels of nursing staff with initial priority given to Level 2 and Level 3 nurses.

Recommendation 11 *page 31* That Queensland Health adopts and evaluates the proposed post graduate education pathway.

Recommendation 12 *page 31* That the outcomes of the current trial programs being sponsored by the Australian Vice Chancellors Committee (AVCC) on Enrolled Nurse to Registered Nurse transition be reviewed by the standing committee on completion of the trials and that recommendations be made by Queensland Health to Department of Education Training and Youth Affairs (DETYA).

Recommendation 13 *page 32* That Queensland Health supports the principle of recognition of prior learning of Enrolled Nurses who wish to enrol in an undergraduate nursing course.

Recommendation 14 *page 32* That Queensland Health recognises the value of Assistants in Nursing and Enrolled Nurses as a source of future Registered Nurses and develops strategies for advancement within the nursing structure.

Recommendation 15 *page 33* That a statewide system is developed to organise rotations of nursing staff from rural and remote locations between tertiary and secondary locations.

Recommendation 16 *page 33* That Queensland Health investigates in conjunction with each of the universities offering nursing programs the feasibility of establishing Clinical Professor of Nursing positions.

Recommendation 17 *page 34* That a process of recruiting new graduates be established to meet new graduate needs as well as the needs of Queensland Health and that this process be managed and developed by a senior nurse in conjunction with a representative nursing committee.

Recommendation 18 *page 34* That a working party including key stakeholders be established as a matter of urgency to explore the impact of capital works programs for the employment of new graduates.

Recommendation 19 *page 36* That a review of funding graduate transition support be undertaken to inform the Casemix funding model. The review should include costs of funding for back-fill of preceptors and supernumerary costs of placing new graduates in locations where they are required to undertake a more advanced role such as in small rural health facilities. The review should be based upon the *Queensland Nursing Council Position Statement on Transition Support Processes for Beginning Level Nurses*.

Recommendation 20 *page 36* That the funding for new graduates be quarantined to ensure funding for new graduate support processes meet the standards in the Queensland Nursing Council (QNC) position statement.

Recommendation 21 *page 36* That specific aspects from the *Queensland Health Indigenous Workforce Management Strategy* which relate to nursing need to be implemented particularly those related to the requirements of transition support appropriate to the cultural needs of Indigenous Nurses.

Recommendation 22 *page 37* That a project be funded by Queensland Health to further develop and implement the *Best Practice Model for Recruitment* (developed by the Taskforce) in partnership with Health Service Districts according to specific nursing requirements.

Recommendation 23 *page 37* That Queensland Health redesigns the current central process of recruitment in liaison with key stakeholders to adopt the *Best Practice Model of Recruitment* as the approach for recruiting nurses.

Recommendation 24 *page 37* That, as a matter of urgency, Queensland Health educates staff on the processes to ensure principles of meritorious selection are adhered to.

Recommendation 25 *page 37* That Queensland Health assesses the availability of computer software and hardware for nurses in rural and remote locations.

Recommendation 26 *page 38* That *"Queensland Health's Nursing Workforce – A framework for evaluating the balance between supply and demand"* be applied generally and as a priority to systematically evaluate nursing workforce requirements for cardiac, aged care, rural and community nursing (Appendix 3).

Recommendation 27 *page 38* That the Health Advisory Unit (Nursing) adopt a role in assessing the analysis of workforce planning data on an annual basis for the formulation of strategic advice and direction.

Recommendation 28 *page 38* That Queensland Health clearly articulates the meanings of the "Model of Care" that forms the basis for service delivery and that appropriate education for employees is provided and is implemented in the workplace.

Recommendation 29 *page 39* That Queensland Health funds the development of a Business Planning Model to provide a method of determining appropriate long term nursing staffing levels necessary to meet specific service requirements.

Recommendation 30 *page 39* That Health Service District based forums are developed to monitor nursing workloads and associated issues and develop strategies in response in accordance *with Queensland Health Certified Agreement No.3 (1998)*.

Recommendation 31 *page 39* That in line with the strategic direction for Queensland Health, the current Health Advisory Unit (Nursing) is responsible for:

- the development of the strategic direction and vision for nursing in Queensland Health
- raising the profile of nursing
- providing professional leadership
- developing an approach that is consistent with Queensland Health organisational solutions
- other issues identified in this report.

Recommendation 32 *page 40* That the Health Advisory Unit (Nursing) be resourced and structured appropriately so that it can fulfil its responsibilities (Appendix 2).

Recommendation 33 *page 40* That in the formation of policies affecting nursing, input from the Health Advisory Unit (Nursing) or its designated representative is sought.

Recommendation 34 *page 40* That the Health Advisory Unit (Nursing) develops a communication strategy to disseminate and receive relevant and necessary information to and from nurses throughout Queensland Health.

Recommendation 35 *page 41* That a reference group predominantly of nurses be established by the Health Advisory Unit (Nursing) to review the application of the performance management system for nurses.

Recommendation 36 *page 41* That zonal managers facilitate the further development of models of nursing leadership to extend from larger health services to smaller health services.

Recommendation 37 *page 41*

That mechanisms be developed to provide support services through partnerships which would extend from large health services to smaller health services. Examples of support are:

- mentorship
- orientation and induction processes
- human resource management and industrial relations
- training and professional development opportunities
- leave relief
- quality management
- research
- information technology support
- coordination of undergraduate clinical placement.

Recommendation 38 *page 42*

That the management of patient dependency systems is further developed to ensure data consistency, interrater reliability, feedback mechanisms, and the recognition that nursing clinical judgement is a valid method by which to further assess appropriateness of staffing levels for workload requirements.

Recommendation 39 *page 42*

That patient dependency standards be developed in conjunction with a statewide education program to promote understanding and reliability of the data generated.

Recommendation 40 *page 42*

That the development, implementation and viability of patient dependency occurs for services currently without such systems.

Recommendation 41 *page 42*

That the terms and conditions of appointment to Executive Nursing positions be aligned to the terms and conditions of District Executive Services and that negotiation occurs with appropriate parties to implement the alignment.

Recommendation 42 *page 43*

That a review of the Level 3, Level 4, and Level 5 roles be undertaken and benchmarked. The range of roles and associated responsibilities from Level 3 to Level 5 has broadened and consequently anomalies exist which will require the generic level statements to be reviewed.

Recommendation 43 *page 43*

That as anomalies in the Level 3 salary have been identified immediate action be initiated to address these anomalies.

Recommendation 44 *page 44*

That Queensland Health gives recognition to non-clinical time required for management and other activities for Level 2 and Level 3 nurses in the determination of future staffing levels.

Recommendation 45 *page 44*

That Queensland Health and the Queensland Nurses' Union negotiates to incorporate the role of the Enrolled Nurse within the career structure.

Recommendation 46 *page 44*

That Queensland Health initiates research to investigate the reason for turnover in Health Service Districts that have an abnormally high turnover rate.

Recommendation 47 *page 44*

That a package of reasonable relocation expenses as outlined in IRM2.3-4 be adopted for nurses moving to rural/remote locations.

Recommendation 48 *page 45*

That Queensland Health supports the modification of Public Sector superannuation arrangement to ensure that QSuper meets the needs of a mobile, predominantly female workforce.

Recommendation 49 *page 45* That Queensland Health develop processes to notify Health Service Districts of existing family friendly policies and evaluates the current uptake of these policies for the whole organisation.

Recommendation 50 *page 46* That Queensland Health undertakes an analysis of nurses' childcare needs within the next twelve months in line with whole of government approach to the provision of appropriate extended hours childcare services.

Recommendation 51 *page 46* That Queensland Health provides information statewide about nursing award entitlements and develops strategies to monitor that these conditions are being applied.

Recommendation 52 *page 46* That a project be established to trial rostering practices at six pilot sites representing rural, remote, metropolitan and provincial settings.

Recommendation 53 *page 47* That a standard for new/replacement remote area nurse accommodation be finalised and adopted for rural and remote locations.

Recommendation 54 *page 47* That Queensland Health set a strategic direction for aged care service delivery which includes the role and functions of Registered, Enrolled Nurses, and Assistants in Nursing.

Recommendation 55 *page 47* That within each Queensland Health Zone, aged care nursing specialists are available to provide consultancy and mentorship in respect to aged care service delivery.

Recommendation 56 *page 48* That in accordance with Recommendation Sixteen, Queensland Health investigates the establishment of a Queensland Professor of Gerontology Nursing aimed at improving the health status of older people in Queensland.

Recommendation 57 *page 48* That Queensland Health establishes and promotes continuing professional education opportunities for nurses caring for older clients.

Recommendation 58 *page 48* The Queensland Health endorses the current proposals for the development of the mental health nursing workforce capability as raised within the Mental Health Expert Working Group (Appendix 14). The proposals include:

- the provision of mental health nursing scholarships funded at two thirds of the cost of university fees by Queensland Health
- the allocation of a Project Officer to progress specific nursing issues.

Recommendation 59 *page 49* That a representative group which includes key nursing stakeholders and zonal managers be established to plan and implement the recommendations of the Taskforce and further that this group report six monthly to the Minister on the progress of such implementation.

1.0 Introduction and background

The Ministerial Taskforce — Nursing Recruitment and Retention, was established by the Minister for Health in October 1998 as an initiative of the state government. A Steering Committee for the Taskforce was established to manage the project. The terms of reference were to:

1. Undertake a comprehensive review of the pre and post registration education, training, and staff development needs of nurses to better match workforce planning needs.
2. Develop guidelines for the management of nursing resources and workloads.
3. Promote the introduction of family friendly rostering and management practices.

Members of the Steering Committee

Mr Geoff Carse	Manager, Health Workforce Planning and Analysis Unit, Queensland Health
Ms Janine Walker	Manager, Industrial relations Unit, (Steering Committee member until December, 1998)
Mr Nigel Cumberland	Manager, Employment Relations and Strategies Unit, Queensland Health (Commenced as a Steering Committee member December, 1998)
Ms Linda Dawson	Manager, Southern Zone Coordination Unit, Queensland Health
Ms Cheryl Dorron	Enrolled Nurse, Ministerial Nominee
Ms Anne Garrahy	Queensland Nurses Union (Clinical Nurse Consultant, Nambour Hospital)
Dr Desley Hegney	Professor of Rural Nursing, Toowoomba Health Services and University of Southern Queensland
Ms Laurel McCarthy	District Manager, Cape York District Health Services
Ms Mary Montgomery	Director of Nursing, Toowoomba Base Hospital
Ms Sue Norrie (Chair)	**Principal Nursing Advisor, Queensland Health**
Mr Jim O'Dempsey	Executive Officer, Queensland Nursing Council
Mr Lex Oliver	Professional Officer, Queensland Nurses Union
Mr Lindsay Pyne	District Manager, Princess Alexandra Hospital
Ms Christine Ryan	Director of Community/Director of Nursing, West Moreton Community Health Service
Ms Val Tuckett	Director of Nursing, Townsville General Hospital
Ms Lesley Woolf	Director of Nursing, Mt Isa Hospital

A Project Officer for the Taskforce was appointed. In addition, another Project Officer position was dedicated to the Undergraduate/Graduate Transition Support component.

Project Officer	Ministerial Taskforce — Nursing Recruitment and Retention Ms Suzanne Cadigan
Project Officer	Undergraduate/Graduate Transition Support Ms Judith Sprenger

The project was scheduled for completion by July 1999, when the final report based on Taskforce findings was to be presented to the Minister.

2.0 Project management of the ministerial taskforce

To facilitate project management the Steering Committee established five key areas for investigation to fulfil the Terms of Reference. These were (see Figure 1):

- Corporate approach to nursing
- Best practice model for recruitment
- Undergraduate/graduate transition support
- Supply strategies
- Flexible work environment

Figure 1 *Project management of the Taskforce*

Expert working groups were established for each of the key areas. Each group was chaired by a Steering Committee Member to facilitate communication with the Steering Committee and reduce duplication. Members of the expert working groups were representative of nursing at all levels and drawn from a variety of health services and geographic locations (Appendix 4). Each expert working group was provided with clear guidelines about the breadth of the topic area for which they were responsible and terms of reference developed by the Steering Committee were applied to all expert working groups.

The Steering Committee members expected each expert working group to devise methods to access information from nurses and other sources, base recommendations on this information, and forward recommendations for consideration by the Steering Committee. The breadth of the topic areas for the expert working groups were as follows:

Corporate approach to nursing

addressed corporate issues relevant to nursing, nursing resource management, and the Health Advisory Unit (Nursing). The expert working group also examined professional training and development provision, performance management statewide, and the differences for implementing initiatives for nursing in the following areas:

- Metropolitan
- Provincial
- Rural
- Remote

Best practice model for recruitment addressed marketing, advertising and selection processes.

Undergraduate/graduate transition support addressed undergraduate nursing and support for the graduate year (transition support).

Supply strategies addressed the current and future number of nurses and qualifications needed to meet workforce needs.

Flexible work environment addressed the following topics:

- Models of nursing service delivery
- Skill mix
- Patient dependency
- Workloads
- Rostering practices
- Family friendly and flexible work practices
- Rewards and opportunities
- Career structure.

Terms of reference – all expert working groups

The terms of reference were to:

1. Review issues and identify gaps
2. Prepare strategies to explore gaps in the data
3. Review data and its analysis
4. Identify options and prepare recommendations for consideration by the Ministerial Taskforce — Steering Committee.

In addition, the Steering Committee included two previously formed groups — the Mental Health and Aged Care Nursing Groups — into the Taskforce. These groups were formed as a result of specific workforce needs previously identified. The Steering Committee considered their inclusions as a positive initiative to potentially reduce duplication.

A small expert working group was developed to coordinate and oversee research for the Taskforce and assist with the analysis of incoming data (Appendix 4). The Research Expert Working Group was subsumed from the Steering Committee with additional members drawn from the Health Workforce Planning and Analysis Unit (Queensland Health). The expert working group accessed nursing workforce data (Health Workforce Planning and Analysis Unit) to accurately analyse retention rates for nurses working in Queensland Health. These additional expert working groups also applied the terms of reference developed by the Steering Committee. Expert working groups were provided with all relevant workforce data.

Communication strategy for the Ministerial Taskforce

To inform nurses employed in Queensland Health about the Taskforce, a communication strategy was developed. The aim was to communicate effectively about project initiatives, activities, and recommendations to the nursing profession and other identified stakeholders. Strategies used included the use of written publications (*Health Matters, Forum, Queensland Nurse*), direct letters to Directors of Nursing and District Managers, e-mail (user groups established for Levels 3, 4 and 5 nurses), Queensland Health Information Network (QHiN) and direct mail outs to nursing professional organisations. Information provided

included the project scope, expert working groups, how to provide input and emergent Taskforce themes.

The Project Officer for the Undergraduate/Graduate Transition Support Expert Working Group conducted awareness sessions throughout Queensland. This was done by telephone or face-to-face with key stakeholders, including representatives from universities, hospitals (private, public, rural and remote), community, domiciliary, aged care, Queensland Nursing Council, Queensland Nurses' Union and Aboriginal and Torres Strait Islander peoples.

3.0 Data collection

Recognising there are many different ways knowledge can be generated through research and that one methodology should not be seen as superior to another, the Steering Committee decided on the use of triangulation methodology and methods (data triangulation; investigator triangulation; methodological triangulation) to increase validity and to ensure inclusion of the perspective of different stakeholders (all levels of nurses, District Managers) (Denzin, 1989). This allowed for the creation of a data cross checking system that ensured the rigor of the project (Denzin, 1989). The advantages of triangulation include:

- overcoming the bias of a single-method; single-observer
- increasing confidence in the results
- allowing the development and validation of instruments and methods.

Triangulation methodology allowed for the inclusion of quantitative data (Queensland Health Workforce Statistics; Queensland Tertiary Admissions Centre data and telephone and mailed questionnaires) and qualitative data (submissions, focus groups, expert working groups and interviews). It therefore included investigator triangulation (two or more skilled researchers with different expertise examine the data); and data triangulation (the use of multiple sources – from different people, from different places and from people at different employment levels). This ensured that the data could be used by expert working groups as a basis for the development of the recommendations. A total of five hundred nurses contributed to data collection through expert working group membership and input into data collection methodologies.

3.1 Determining the rigour of the study

Sandelowski (1986) states that the categories to be considered in determining rigor of the study (and therefore credibility of the research findings) are:

Credibility is the extent to which the participants and the readers of the study recognise the experiences described in the research as being similar to their own. If nurse readers of this study recognise their practice and the issues related to recruitment and retention, then credibility for this study has been achieved with the nurses in Queensland (Roberts and Taylor, 1998).

Fittingness refers to the extent to which the project findings fit into other contexts outside of the study setting. Thus, the Steering Committee needed to ensure that Queensland nurses reading the study would find meaning and relevance for their own experiences (Roberts and Taylor, 1998).

Auditability is the production of a decision trail that can be scrutinised by other researchers to determine the extent to which the project has achieved consistency in its methods and processes. A high degree of auditability

would allow another researcher to use a similar approach and possibly arrive at a similar or comparable conclusion. This study documents the data collection of the project, thus allowing other researchers to undertake a similar study (Roberts and Taylor, 1998).

3.2 Limitations of the study

Whilst the Steering Committee acknowledged that the sampling methods did not access every nurse employed by Queensland Health and the findings from the interpretative research (qualitative data) cannot be generalised in the way that the quantitative data can be, it recognised that interperative research is the most appropriate approach as the study involved human feelings, actions and values. It is acknowledged that the interpretative research data are not able to be generalised to the total Queensland nursing population. Further, it acknowledged that while care was taken to avoid leading questions in the focus groups, that the focus groups data may not have captured the issues fully. Every effort, however, has been made to include conflicting viewpoints that make up the discourses of recruitment and retention of nurses in Queensland. In addition, the Steering Committee expressed the view that quantitative data indicating the vacancy levels for nursing would have been valuable information. Accurate vacancy data are currently not able to be accessed for the Queensland Health nursing workforce. It is noted that proportionally Level 3 representation was higher than that of Level 1 and Level 2 particularly in the focus groups.

3.3 Data collection tools

The mechanisms for data collection were:

1. Nursing Workforce Data, Queensland Nursing Council registrations and Queensland Tertiary Admissions Centre information.
2. A structured questionnaire telephone interview of Directors of Nursing employed by Queensland Health.
3. Workshops/focus groups (13)
4. Surveys (2)
5. *Invitation for Submissions* information to the Taskforce (92)
6. Expert working groups

3.3.1 Nursing Workforce Data Collection, Queensland Nursing Council registrations, and Queensland Tertiary Admissions Centre (QTAC) Information

Quantitative data were collected from the Health Workforce Planning and Analysis Unit (Queensland Health) using the Staff Profile Information System (SPIS). These data were used extensively to examine the nursing workforce's growth trends and turnover rates related to age, gender, and length of nursing experience and location.

Further, quantitative data were accessed from the Queensland Nursing Council and Queensland Tertiary Admissions Centre to analyse the rate of enrolments of students into nursing courses, the percentage of students commencing courses, and those registering as a registered nurse.

3.3.2 Structured telephone interview survey

Members of the Best Practice Model for Recruitment Expert Working Group devised a structured telephone interview using open-ended questions to gather data from Directors of Nursing employed by Queensland Health. The aim of the telephone interviews was to elicit information from the perspective of a range of senior nurses throughout Queensland about current practices used to recruit nurses and their evaluation of the effectiveness of these processes. From a total of 189 Directors of Nursing employed by Queensland Health, 36 were purposively chosen to cover a wide range of geographic locations. Telephone interview was chosen as this was considered to be cost-effective compared to other interview options. The final interview tool (Appendix 5) was applied by each member of the expert working group who individually interviewed six Directors of Nursing. The resultant data were used to provide information for the development of recommendations by this expert working group.

3.3.3 Workshops/focus groups

Thirteen workshops were conducted to generate qualitative data from the participants. In all cases the sampling was purposive because the criteria used to selected participants had been decided in advance by the Steering Committee. These criteria included – nurses from all contexts of practice (rural, remote area, provincial, metropolitan); all types of nurses and nursing roles, (nursing specialties, generalist nurses, registered nurses, enrolled nurses) all levels of nursing through the career structure (Level 1 to Level 5), and non nurses for example, District Managers.

(a) Corporate approach to nursing in Queensland Health — workshop

The aim of the workshop was to provide the opportunity for a range of Queensland Health personnel to present expert advice regarding the issues to be examined. The workshop participants discussed the following issues:

- Queensland Health services are delivered using different approaches in a variety of geographical locations. Appropriate principles must be considered when implementing organisational initiatives in metropolitan and non-metropolitan areas
- Queensland Health's approach to nursing, nursing resource management, and the Health Advisory Unit (Nursing)
- professional development and training provision
- performance management statewide.

The expert working group nominated participants for this workshop to ensure that the data collected would be representative of nurses and others employed in Queensland Health.

Participants were drawn from:

- all levels of nursing throughout Queensland (Table 1)
- Queensland Health Branches such as the Health Advisory Unit — Nursing, Zonal Coordination Units, Organisational Development Branch and Aboriginal and Torres Strait Islander Branch
- Queensland Nurses Union, Director of Nurses Association
- District Managers.

Table 1 *Nursing representation — corporate approach workshop*

Level	*Participants*
Level 5	4
Level 4	5
Level 3	4
Level 2	2
Level 1	3
Enrolled Nurse	1

(b) Clinical placements of undergraduate nursing students workshop

The aim of the workshop was to identify issues related to undergraduate clinical placements in Queensland Health and non-Queensland Health health facilities. Invitations to participate were extended to nursing representatives directly involved with clinical placements. Participants were drawn from universities as well as the clinical sector. A total of thirty participants attended.

Participants were asked to formulate realistic strategies to decrease the impact of the identified problems. To do this, the participants worked in small rotational groups to respond to specific focus group questions. Participants identified problems with the current situation and strategies were then developed and recorded for consideration by the Undergraduate/Graduate Transition Support Expert Working Group.

Representatives for the workshop were drawn from:

- Australian Catholic University
- Central Qld University
- Griffith University
- James Cook University
- Queensland University of Technology
- University of Southern Queensland
- Bundaberg Base Hospital
- Cairns Base Hospital
- Gold Coast Hospital
- Logan Hospital
- Mater Adult Public Hospital
- Prince Charles Hospital
- St Vincents de Paul
- Rockhampton Base Hospital
- Royal Brisbane Hospital
- Townsville General Hospital
- Kingaroy Hospital
- Qld Nursing Council
- Princess Alexandra Hospital
- Eventide Nursing Home
- Cherbourg Hospital

(c) Statewide workshops/focus groups – Queensland Health

The Steering Committee was interested in the 'factors impacting upon recruitment and retention of nurses employed by Queensland Health'. The workplace was recognised as the appropriate place to elicit such information. Ten sites in Queensland were selected to conduct the focus groups. These sites were purposively chosen to ensure that a cross section of Registered and Enrolled Nurses employed by Queensland Health contributed to the data collection. The workshops were held in Cairns, Townsville, Weipa, Mt Isa, Longreach, Gladstone, Brisbane (Princess Alexandra Hospital and Redcliffe Hospital), Toowoomba and the Gold Coast. The sites selected ensured involvement of a wide range of nurses from a variety of health care settings and locations.

The program for the workshops consisted of two distinct approaches (Appendix 6). The first half of the workshop elicited information by asking a standard set of questions devised by the Flexible Work Environment Expert Working Group (Appendix 7). The remainder of the workshop was used to consult with nurses about emergent themes (or recommendations) developed for the Taskforce by the Corporate Approach to Nursing, Best Practice Model for Recruitment and Supply Strategies Expert Working Groups.

Consultation involved presenting the emergent themes and asking the groups the following questions:

(i) Did they view the themes as realistic, useful, and achievable?

(ii) Were there any amendments that in their view would enhance the quality of the themes?

The workshops were attended by 204 nurses from the following levels and geographic locations:

Table 2 *Statewide workshops participation*

Level	*Participants*
Level 5	24
Level 4	17
Level 3	91
Level 2	28
Level 1	21
Enrolled Nurse	23

Place of employment

Alpha Health Service District
Aramac Health Service District
Atherton Health Service
Aurekun Hospital
Ayr Hospital
Baillie Henderson
Baralaba Hospital
Barcaldine
Biloela Health Service District
Blackall
Bundaberg Health Service District
Caboolture Hospital
Cairns Community Health Service
Cairns Base Hospital
Centre for Rural and Remote Health
Cherbourg Hospital
Cloncurry Hospital
Coen Health Service District
Dalby

Doomadgee
Eventide Nursing Home (Sandgate)
Gallon Health Service
Gladstone Hospital
Gold Coast Hospital
Gold Coast Mental Health Unit
Herberton
Ingham Health Service
Innisfail Hospital
Ipswich Hospital
Julia Creek
Keperra Hospital
Kingaroy Hospital
Kirwan Hospital
Kowanyama
Lochhardt River
Logan Hospital
Longreach Hospital
Mapoon
Mater Adults
Mater Children's
Mater Private
Mater Public
Moura Hospital
Mt Isa Base Hospital
Mt Lofty Heights Nursing Service
Murgon
Muttaburra
Nambour Hospital
Napranum
North Queensland Rural Training Unit
Oakey Health Service
Oncology Nurses Group
Pormpuma
Prince Charles Hospital
Princess Alexandra Hospital
Redcliffe Hospital
Redland Health Service District
Rockhampton Base Hospital
Royal Brisbane Hospital
Royal Womens Hospital
RYDHS
Southern Downs
St Pauls Terrace Child Health
Toowoomba Base Hospital
Townsville General Hospital
Tully Hospital
Weinholt Nursing Care Unit
Winton Hospital
Yarrabah Health Service

(d) Queensland Nursing Council — assessment against Queensland Nursing Council standards of new graduate transition support in selected health care agencies in Queensland.

Through the Queensland Nursing Council (QNC), public and private health care agencies in Queensland who employ beginning level Registered Nurses were accessed. Information provided by Queensland Health and the Private Hospitals Association of Queensland was utilised to identify the agencies that employed beginning level Registered Nurses. Selection of participating Health Care Agencies was based upon the following inclusion criteria.

1. number of beginning level registered nurses employed
2. willingness to participate in the review
3. feasibility of accessing the health care agencies within the proposed time frame.

Following identification of the participating health care agencies, consent was obtained from the Directors of Nursing to participate in the review. Beginning level nurses and preceptors chosen to participate in the study were selected in consultation with the Directors of Nursing.

Data were collected through face-to-face interviews using a structured interview tool (Appendix 8) with the Directors of Nursing (or their nominees) and through focus groups (Appendix 9) with beginning level Registered Nurses or preceptors.

3.3.4 Surveys

(a) Statewide workshop survey

A survey was administered to workshop participants at the ten sites. The survey was developed by the Flexible Work Environment Expert Working Group to gather further clarifying information as a basis for formulating recommendations.

(b) Registered Nurse (1st year graduate) questionnaire

This questionnaire was developed by the Undergraduate/Graduate Transition Support Expert Working Group (Appendix 10). Ten Registered Nurses who completed their graduate year in 1998 were randomly selected to pilot the questionnaire. The nurses participating in the pilot study were excluded from the sampling for the postal survey. Following adjustment to the questionnaire, which incorporated changes from the piloting of the tool, 150 registered nurses (representing 94 per cent of the total number of nurses who completed their graduate year in 1998), were randomly selected from a data based generated by the Health Workforce Planning and Analysis Unit of Queensland Health. Thirty-nine of the questionnaires were returned (a return rate of 28 per cent).

3.3.5 Invitation for Submissions information to the taskforce

Invitation for Submissions were broadly distributed to all nurses employed by Queensland Health. (Appendix 11). The *Invitation for Submissions* were sent to Directors of Nursing and District Managers across all Queensland Health sites; via e-mail to all Level 3 and 4 nurses with access; to Special Interest Groups; and to the Queensland Nurses' Union. The *Invitation for Submissions* were published in Nursing Journals such as the *Forum* (Queensland Nursing Council) and the *Queensland Nurse* (Queensland Nurses' Union).

A total of 92 submissions (53 from rural/remote area locations, 39 from metropolitan locations) were received. These submissions ranged from a small number of individual contributions to submissions representing whole nursing services in hospitals, professional and industrial organisations. It was noted that one submission received was developed by the Queensland Nurses' Union on behalf of 15,100 members employed by Queensland Health.

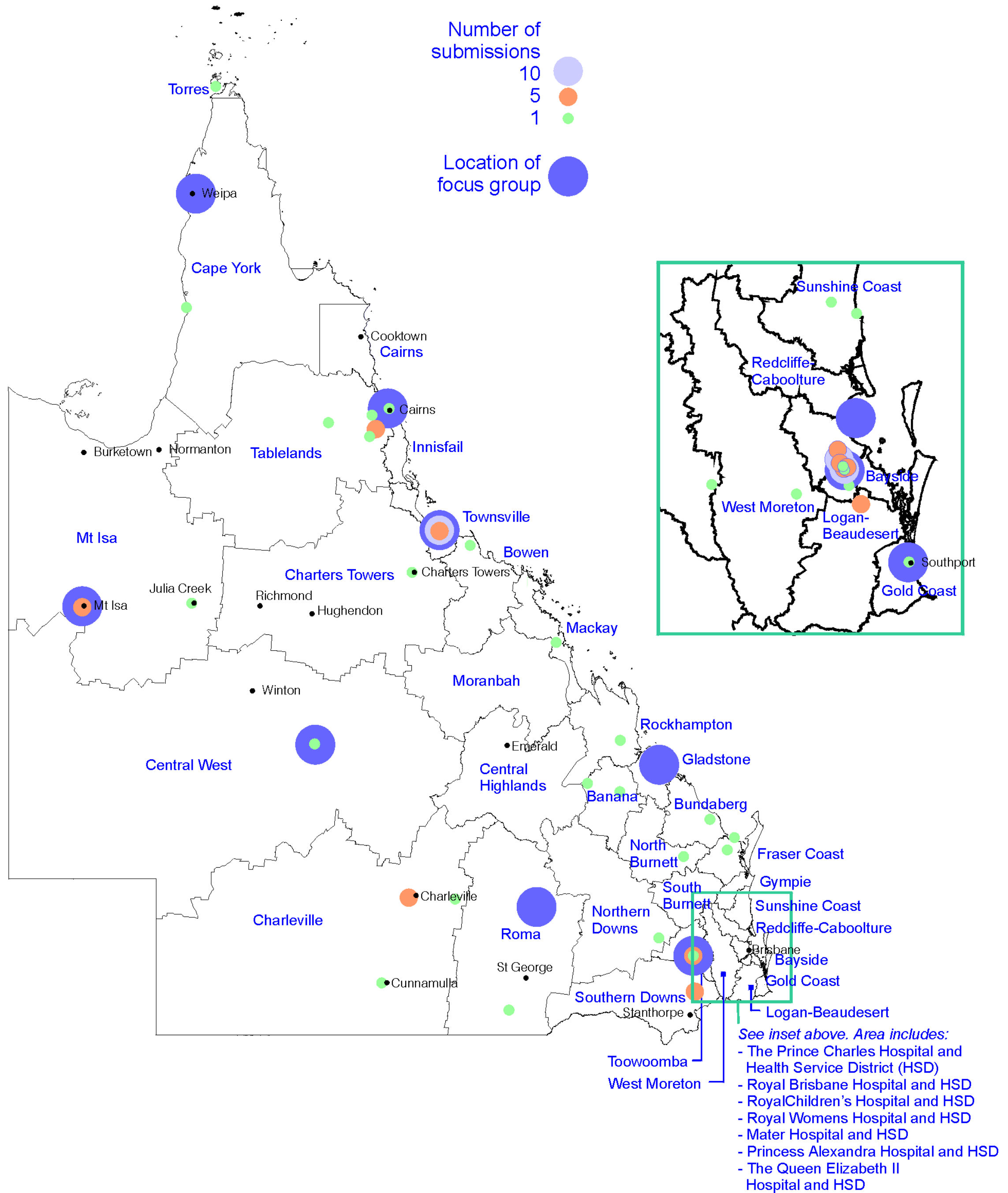
3.3.6 Expert working groups

Discussion and recommendations of the five expert working groups (Corporate Approach to Nursing, Best Practice Model for Recruitment, Undergraduate/Graduate Transition Support, Supply Strategies, and Flexible Work Environment) were informed by the literature and the information gathered from the six methods previously outlined. Consequently, the recommendations from the expert working groups have been based on the research findings of the Taskforce and supplemented by the expert opinion of the expert working group (Level Four scientific evidence, Cochrane collaboration).

The Undergraduate/Graduate Transition Support Expert Working Group also collected data from the Queensland Tertiary Admissions Centre (QTAC) and QNC. These data were used to inform the expert working group's recommendations with regard to entry into nursing and nursing transition programs.

The many different areas of the State, which contributed data to the expert working groups, are identified in Figure 2.

Figure 2 *Taskforce participation – location of submissions and focus-groups*



4.0 Discussion and recommendations

The Terms of Reference of the Taskforce were to:

1. Undertake a comprehensive review of the pre and post registration education, training and staff development needs of nurses to better match workforce planning needs.
2. Develop guidelines for the management of nursing resources and workloads.
3. Promote the introduction of family friendly rostering and management practices.

As stated earlier in this report, seven data collection methods (quantitative and qualitative) were used to generate data and review their significance to the Terms of Reference of the Taskforce. The data were collated by each of the expert working groups and draft recommendations were made to the Steering Committee. In some instances the Steering Committee, working on the data and the recommendations from the expert working groups, could see future impacts for the nursing workforce. As such, the Steering Committee generated further recommendations that aimed to correct these impacts. This section of the report will provide a discussion of the issues with regard to the data collected and their relevance to the Terms of Reference of the Taskforce.

4.1 To undertake a comprehensive review of the pre and post registration education, training and staff development needs of nurses to better match workforce planning needs.

The Undergraduate/Graduate Transition Support and the Supply Strategies Expert Working Groups focussed on this term of reference. Issues which arose from the data collected and expert working group discussion included:

- promotion of nursing as a desirable career
- undergraduate entry into nursing
- retention and number of undergraduate pre-registration students within the university system
- aspects related to the design of undergraduate pre-registration courses (preceptorship, course content, partnerships between the clinical environment and the higher education section in Queensland)
- graduate transition processes and their relationship to the *Queensland Nursing Council Position Statement on Transition Support Processes for Beginning Level Nurses*
- access to post graduate education
- access to continuing professional education and staff development.

4.1.1 Pre-registration education and training to better match workforce planning needs

Recruitment issues related to pre-registration undergraduate nursing programs included the marketing of nursing as a desirable career to high school students (for example, how nursing currently marketed the ability to undertake work experience if interested in a nursing career) and the incentives which could be used to increase the number of year 12 students choosing nursing as a career (for example OP Bands, undergraduate scholarships).

(a) Marketing and admission to higher education institutions

Discussion within the Expert Working Group – Undergraduate/Graduate Transition Support, highlighted the fact that Queensland Health does not have a policy on work experience placement for high school students who may wish to work in a Queensland Health facility. This, they believed, was counterproductive to encouraging students to choose nursing as a career. Compounding the issue was the lack of information provided by careers advisors at the High School level about nursing as a career. Thus, students who could not access the higher education sector's 'open days' were disadvantaged in their level of knowledge about nursing, and what was needed for entry into nursing. It was also apparent that there is no marketing approach to promote nursing in secondary schools by Queensland Health.

Additionally, data provided by Queensland Tertiary Admissions Centre indicate that the number of year 12 students entering pre-registration nursing courses has declined by nearly half since 1994 while the number of mature aged students enrolling in pre-registration undergraduate courses has increased (Table A 3, Appendix 1).
It is recommended:

Recommendation 1

That Queensland Health develops a process to facilitate work experience and marketing for secondary school students and explores a collaborative approach with Education Queensland for advancing nursing as a career.

Further a major theme (more than 25 per cent of the participants noted this) which emerged from the *Invitation for Submissions* was the need for a bonding/scholarship system to subsidise nursing study. This was in return for a guaranteed and defined term of employment at the completion of pre-registration undergraduate study and at the post registration levels.

Queensland Health currently offers scholarships in dentistry, medicine, nursing (indigenous students only), nutrition/dietetics (indigenous students only), occupational therapy, pharmacy, physiotherapy, podiatry, psychology (clinical masters), radiography, social work and speech pathology. The introduction of undergraduate nursing scholarships, targeted specifically for employment in rural and remote areas will ensure all health disciplines are represented within the Rural Scholarship Scheme. Further, it will potentially contribute to redressing the maldistribution of the nursing workforce between metropolitan and rural and remote areas. It is recommended:

Recommendation 2

That Queensland Health examines the viability of establishing a scholarship system to support the employment of nurses to work in rural and remote areas.

Additionally, the Expert Working Group — Best Practice Model for Recruitment found there was a lack of career advice available to nurses currently employed by Queensland Health. This position was also supported by the Undergraduate/Graduate Transition Support Expert Working Group. Respondents in the statewide focus groups endorsed the concerns of the expert working group. The establishment of a Nursing Career Advisory Service was proposed by the expert working group. This service could be of benefit to promote nursing as a career to those considering entering nursing and to Registered and Enrolled Nurses currently in the Queensland Health workforce. It is recommended:

Recommendation 3

That Queensland Health develops and implements a framework for a Nursing Career Advisory Service to:

- *promote nursing as a career*
- *improve recruitment in nursing for Queensland Health*
- *develop the advisory service for undergraduates, new graduate and post graduate nurses*
- *act on the recommendations that relate to career advice from the Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN) report of August 1998*
- *incorporate the strategic direction of the Queensland Health Indigenous Workforce Management Strategy.*

An important consideration in undergraduate pre-registration nursing entry is the OP Band. This was considered by the Expert Working Group – Undergraduate/Graduate Transition Support. Data collected from Queensland Tertiary Admissions Centre suggest that the OP band of pre-registration nursing students entering the higher education sector has remained relatively stable over the past five years (Appendix 12). The Expert Working Group – Undergraduate/Graduate Transition Support believed there was a need for wide dissemination of the Discussion Paper generated by Queensland Health. This paper informed this expert group in respect to the perception that students of lower general ability are being accepted into nursing courses in order to fill quotas.

Analysis of the data provided by the Queensland Tertiary Admissions Centre indicates that student intake numbers into pre-registration undergraduate nursing courses in Queensland Universities has been relatively stable at around 1200 for the past five years. Assuming current university attrition rates of approximately 40 per cent, in (nursing courses) a simple model was developed to project Queensland Health's Registered Nurse workforce forward ten years. This model suggests the current intake numbers into the higher education sector should be maintained to ensure the size of the registered nurse workforce in Queensland remains constant (Health Workforce Planning and Analysis Unit). It is recommended:

Recommendation 4

That Queensland Health advocates to the Department of Employment Training and Youth Affairs (DETYA) and Queensland Universities that the current intake of 1200 undergraduate pre-registration nursing students be maintained for the next five years. This is in order to ensure 800-900 nursing graduates are available each year to meet projected medium to long term workforce demands.

(b) Curriculum design and clinical placement

The Steering Committee recognised that by keeping the current intake at 1200 to ensure 800-900 nursing graduates some difficulties will be created in the short term. These difficulties are linked to the redevelopment projects and reduction of inpatient bed numbers. To meet future workforce requirements for Queensland Health, the Steering Committee determined that a planned approach to the employment of new graduates was paramount.

Data from the *Invitation for Submissions,* the Expert Working Group – Undergraduate/Graduate Transition Support, and the Clinical Placement of Undergraduate Nursing Students Workshop highlights issues to be addressed relating to clinical placement of students. The two major issues discussed were preceptor training and overload and partnerships between the higher education sector and Queensland Health:

- **Preceptor training and overload**. The perceptions of the participants in the Undergraduate / Graduate Transition Support awareness groups were that funding for training and staff development of Registered Nurses, who had responsibility for the education of pre- registration nursing students in the clinical setting, was not seen as a priority by their managers. They stated that current budget allocations do not allow for the employment of relief staff to backfill the employees needed to provide clinical education. It was noted that rural and remote areas were even more affected than metropolitan sites in this regard. Additionally, the participants in Clinical Placement of Undergraduate Nursing Students Workshop noted there was an inconsistency in remuneration for hospital based facilitators organising undergraduate pre-registration placements. The lack of remuneration and other aspects relating to preceptor support such as rostering staff and skill mix were also considered to be major issues in the *Queensland Nursing Council — Assessment against the Queensland Nursing Council Standards of New Graduate Transition Support in Selected Queensland Health Care Agencies*. It is recommended:

Recommendation 5

That Queensland Health reiterates its commitment as a provider of clinical educational experience and allocates resources appropriately.

- **Partnerships between the higher education sector and Queensland Health**. Data gathered from the awareness sessions – Undergraduate/ Graduate Transition Support and from the *Invitation for Submissions* suggested that partnerships and consultation between universities and health service providers would facilitate higher learning and undergraduate pre-registration nursing education. Some participants in the *Invitation for Submissions* suggested joint partnerships would ensure better communication between the higher

education sector and health services thus ensuring congruence between the objectives of the students' clinical placement and the health service. This theme was also supported by the participants in the workshop for Clinical Placement of Undergraduate Nursing students and the Expert Working Group – Supply Strategies. Participants noted there were disparities between the higher education sector and health care providers and between higher education providers and health service provider expectations. With regard to Curriculum Design, it was acknowledged that the Queensland Nursing Council has responsibility for the accreditation of nursing programs at the pre-registration undergraduate level. However, the participants in the workshop — Clinical Placement of Undergraduate Nursing Students, noted there was a need for clinical placement objectives to be integrated into the clinical environment. They also believed that some clinical placements were of inadequate length. To overcome these and other issues, and to facilitate partnerships between the higher education sector and Queensland Health, it is recommended:

Recommendation 6

That Queensland Health establishes and resources a representative standing committee to facilitate the development of partnerships between the health and higher education sector to address ongoing issues.

4.1.2 Post registration education and training to better match workforce planning needs.

Concerns regarding recruitment and retention of nurses into the Queensland Health Workforce centered upon post registration education, training and staff development. Significant themes included access to courses, cost of the courses, accommodation availability and suitability when undertaking courses, availability of relief staff, travel considerations and suitability of courses to the clinical environment and career advancement.

(a) Access to courses.

The data from statewide focus groups, the telephone surveys of the Directors of Nursing, and *Invitation for Submissions* indicate there are problems with access to education and training at the post registration level. The participants in the focus groups emphasized that there were inequities in what was available for other health professionals and what was available for nurses. They stated that in particular the availability of scholarships (Recommendation Two), funded educational opportunities, accessing support for study leave, adequate accommodation and conditions were lacking for the majority of nurses employed by Queensland Health.

Over 25 per cent of respondents to the *Invitation for Submissions* stated that the financial burden of further study was a disincentive. Strategies suggested by respondents to overcome barriers to education and training included quarantining of funds for nursing education, training and nursing staff development (over 25 per cent of respondents), and a coordinated statewide approach to all forms of nursing training. Monitoring nursing staff development was also suggested with this

linked to performance review of health service managers and employees. It is recommended:

Recommendation 7

That, consistent with the Queensland Health Training Plan, the Health Advisory Unit (Nursing) coordinates the development of a training and development framework for nursing.

(b) The suitability of courses to the clinical environment and the needs of Queensland Health

Participants in the statewide focus groups stated that alternative and creative clinical education options for nurses in rural and remote area were needed to address current inadequacies in education and training programs. Further, participants in the statewide focus groups, *Invitation for Submissions*, and Supply Strategies Expert Working Group believed there were gaps between industry needs and the current post graduate courses offered by Queensland Universities. They questioned the relevance of higher education programs to contemporary health care delivery. Closer liaison was suggested between Queensland Health — Health Advisory Unit (Nursing) and the tertiary education sector to improve the relevance of programs to clinicians and clinical areas. They noted that there is currently no formalised process in place to manage such issues and suggested a Standing Committee be formed to facilitate a proactive approach within the context of the changing health care environment. This Standing Committee would be responsible for liaison between Queensland Health and the tertiary education sector with terms of reference incorporating the identified workforce education and training needs. It is recommended:

Recommendation 8

That a representative Standing Committee be developed between Queensland Health — Health Advisory Unit (Nursing) and the tertiary sector to match post graduate and enrolment courses to industry needs.

Recommendation 9

That the Health Advisory Unit – (Nursing) initiates statewide education programs in the case where there are identified workforce requirements.

Participants in the statewide focus groups noted that negative aspects of performance management included lack of management training and failure to implement performance management processes effectively. Respondents in the *Invitation for Submissions* also noted that closed management styles were maintained by untrained managers. Thus, the need for leadership development and the existence of restrictive management practices, both within nursing and the broader health environment, were consistent themes expressed by nurses statewide. The participants in the focus group recognised that the existing *Graduate Certificate in Management* offered by Queensland Health was available to Level 2 and Level 3 nurses. However, they considered the clinical nature of the Level 2 and Level 3 roles resulted in different learning requirements to those available in the existing course. Additionally the Expert Working Group – Flexible Work Environment noted that nurses in the statewide focus group and statewide workshop survey believed that Level 3 workloads had increased and management training of Level 2 nurses was

needed as this role has expanded to include management functions.

To address these deficits it was believed by the participants in the focus groups that Level 2 and Level 3 nurses should be prioritised for nursing specific management programs given the direct interaction of these levels within the nursing team. It is recommended:

Recommendation 10

That there is development, implementation and evaluation of appropriate staff development management programs for all levels of nursing staff with initial priority given to Level 2 and Level 3 nurses.

(c) Career advancement related to education and training

Data from the statewide focus groups suggest there is a need to recognise the value of work based learning for the development of competence. Existing statewide initiatives such as the *Critical Care Nurse Education Framework* (See Figure A 6, Appendix 1) were considered positive. This framework could be applied to other areas of clinical education and training. Participants considered clinically based units of study should be given appropriate credit by higher education providers. The Expert Working Group – Supply Strategies developed the *Post Graduate Clinical Education Pathway.* It was recognised by members of this expert working group that the implementation of work based programs should be in response to demonstrated workforce deficits. This would potentially result in a positive outcome for Queensland Health especially in the area of standards of patient care. It is recommended:

Recommendation 11

That Queensland Health adopts and evaluates the proposed post graduate education pathway.

Recruitment and retention issues relating to career advancement were linked to the advancement of the knowledge of the Enrolled Nurses, unregulated care providers and the Registered Nurse workforce.

(d) The Enrolled Nursing workforce and unregulated care providers

Enrolled Nurses who participated in the statewide focus groups expressed concern that there is no consistent recognition of prior learning for enrolled nurses admitted to pre-registration undergraduate nursing courses. This created inequities for Enrolled Nurses seeking to progress their career through conversion from Enrolled to Registered Nurse. The Steering Committee also considered the data on progression by Enrolled Nurses to Registered Nurse status and agreed there was inadequate recognition of prior learning given by the Queensland Universities. It is recommended:

Recommendation 12

That the outcomes of the current trial programs being sponsored by the Australian Vice Chancellors Committee (AVCC) on Enrolled Nurse to Registered Nurse transition be reviewed by the standing committee on completion of the trials and that recommendations be made by Queensland Health to Department of Education Training and Youth Affairs (DETYA).

Recommendation 13

That Queensland Health supports the principle of recognition of prior learning of Enrolled Nurses who wish to enrol in an undergraduate pre-registration nursing course.

The Steering Committee believe there is potential for current Enrolled Nurses and unregulated care providers to enrol in pre-registration undergraduate nursing courses given the identified shortages of registered nurses in other States and Territories. It recognised that Enrolled Nurses and unregulated care providers were an integral part of the health workforce and many had undertaken courses that were accredited by the Industry Training Advisory Board (ITAB). This would provide a clear pathway for career progression for this group. The need for career progression for Enrolled Nurses and unregulated care providers was also highlighted in the data collected from the statewide focus groups. It is recommended:

Recommendation 14

That Queensland Health recognises the value of Assistants in Nursing and Enrolled Nurses as a source of future Registered Nurses and develops strategies for advancement within the nursing structure.

(e) Registered Nurses

Respondents in the *Invitation for Submissions*, statewide focus groups, and the Structured Telephone Interview Survey of the Directors of Nursing, noted nurses employed in rural and remote areas were particularly disadvantaged with regard to access to education and training which leads to career advancement. The participant nurses in the telephone survey noted rural and remote area nursing should be recognised as a nursing specialty. Further, respondents in the *Invitation for Submissions* believed that the nursing career structure does not account for skills, knowledge and further study required to advance. They considered the current career structure to be a disincentive to career progression.

The inequities in the career structure for rural and remote area nurses was raised by members of the Steering Committee, who noted many of the rural and remote health services relied on agency staff as they could not recruit suitably educated and trained nurses.

To overcome inequities highlighted in the statewide focus groups and *Invitation for Submissions,* the Steering Committee considered exchange of rural and remote area nurses with those employed in metropolitan and provincial areas of Queensland would be a positive initiative. This exchange would provide opportunities for staff from smaller health services to access staff development opportunities readily available in larger centres. Staff from rural and remote health services stressed that access to opportunities to extend their skills and knowledge were impeded by distance and cost of travel to larger centres. The data collected from the statewide focus groups and *Invitation for Submissions* confirmed the findings of previous research studies on the education and training needs of rural and remote area nurses (Hegney, Pearson and McCarthy, 1997). It is recommended:

Recommendation 15

That a statewide system is developed to organise rotations of nursing staff from rural and remote locations between tertiary and secondary locations.

The Expert Working Group – Undergraduate/Transition Support, noted that historically nursing has had strong leaders, although these have been traditionally linked to the current nursing career structure of education and management rather than clinical practice and research. The move of nursing education into the higher education sector has strengthened the scientific basis of nursing knowledge and practice, especially with the current emphasis on evidence based nursing practice. Nursing research is still relatively new in Australia (although well established internationally) and the full potential of the contribution from clinical research in nursing and its application to practice is still to be realised. The need to strengthen clinical research in nursing and promote leadership in this area is evident in other Australian States and Territories with the establishment of Professorships of Clinical Nursing research. The expert working party considered the establishment of Professorships in Nursing in Queensland would fill the gap between actual clinical practice and the scientific evidence. A Professor of Clinical Nursing can provide an in-house nursing research and development function at the operational level which aims to examine existing practices and the introduction of more cost effective approaches to service delivery. Changes to existing practices and more cost-effective approaches to service delivery can only enhance recruitment and retention of nurses at these sites. The Steering Committee, after considering these recommendations from the expert working groups, identified investigating the feasibility of the establishing Clinical Professors of Nursing positions. The investigation should include the implications and forecast benefits for Queensland Health and the relationship to recruitment and retention. It is recommended:

Recommendation 16

That Queensland Health investigates in conjunction with each of the universities offering nursing programs the feasibility of establishing Clinical Professor of Nursing positions.

4.2 Develop guidelines for the management of nursing resources and workloads.

The Expert Working Group — Undergraduate/Transition Support, discussed issues and problems related to the recruitment of graduate registered nurses into the Queensland Health nursing workforce, for example, selection processes currently in place such as *Staff Search.* They also discussed aspects related to the retention of new graduates, including current attrition rates after the first year of employment with Queensland Health; current programs offered by individual health services related to transition support; and the new graduates' perceptions of the quality of the transition support programs currently available.

The Expert Working Group – Corporate Approach to Nursing, Best Practice Model for Recruitment, and Flexible Work Environment also addressed Term of Reference number two. Issues arising from the data

which related to the recruitment of nurses included the perception by nurses that marketing and advertising range from being limited to non-existent. Additionally workplace conditions such as lack of childcare, training opportunities, accommodation and reimbursement for relocation to rural areas were deficient. Salary inequities were noted as a consistent theme hindering the recruitment of nurses into career structure positions such as the Level 3 and rural Level 5 positions where requisite roles and responsibilities were inconsistent with remuneration levels. Barriers to retention highlighted through data collection included workload levels, which were considered to be unacceptable, restrictive management practices, and funding restrictions impacting negatively for training provision and opportunities.

Additionally some of the data collected from participants in the study, the expert working groups and the Steering Committee related to both recruitment and retention.

4.2.1 Recruitment of New Graduates

The Expert Working Group – Undergraduate/Graduate Transition Support was informed by the information available on *Staff Search's* activities, data collected from the Structured Telephone Interview Survey of Directors of Nursing (Queensland Health) and statewide focus groups, together with recruitment activities of new graduates in other States and Territories. It was apparent that the current Queensland Health system requires improvement. Findings highlighted the need to ensure an effective recruitment process for new graduates together with the provision of appropriate graduate support. In particular the Undergraduate/Graduate Transition Support Expert Working Group found there was dissatisfaction with the current Graduate Recruitment Campaign (*Staff Search*). This dissatisfaction related to untimely recruitment strategies, the complicated application process, and a lack of consistent information to undergraduate pre-registration students. It is recommended:

Recommendation 17

That a process of recruiting new graduates be established to meet new graduate needs as well as the needs of Queensland Health and that this process be managed and developed by a senior nurse in conjunction with a representative nursing committee.

The other issue raised by the participants in the workshop – Clinical Placement of Undergraduate Nursing Students, related to the impact of downsizing, and/or short term suspension of services, to facilitate movement from old to new facilities. For example, the Princess Alexandra Hospital in 2000 and the Royal Brisbane Hospital in 2001. This issue was also considered by the Steering Committee. It was noted relocation activities would impact upon the employment of staff for these time periods. The Steering Committee determined that a planned approach to the employment of new graduates would be paramount to meeting future workforce needs. It is recommended:

Recommendation 18

That a working party including key stakeholders be established as a matter of urgency to explore the impact of capital works programs for the employment of new graduates.

4.2.2 Retention of new graduates in the Queensland Health workforce

It was apparent there were insufficient data on retention issues, particularly as they related to Transition Support Programs. To gather further information on this issue, the Expert Working Group — Undergraduate/Graduate Transition Support, generated two research projects to gather data in relation to transition support. These were a quantitative survey which was mailed to Registered Nurses who completed their graduate year in 1998, and a qualitative study involving face to-face interviews and focus groups run by the Queensland Nursing Council to identify how health services conformed to the *Queensland Nursing Council Standards 'New Graduate Transition Support'* (Appendix 15). The latter study gathered data from Registered Nurses undergoing transition support in 1999, preceptors, and Directors of Nursing (or their nominees).

Analysis of the data and themes emerging from these two studies related to support (including preceptoring) of new graduates and preparation of the preceptor and their role.

(a) Support of new graduates

With regard to preceptoring of new graduates it was noted that 59 per cent of the participants in the postal survey were satisfied with the preceptoring they received during the first 12 months of their graduate year. However, it was noted that only 44 per cent of participants in this study were orientated to each ward/unit by their preceptor. Further, the QNC study suggested that the graduation transition process was mainly rhetoric and did not conform to the Council Standards (Appendix 15). It was also suggested that this lack of preceptor support and inappropriate rostering practices caused the new graduate to be subsumed into the team as a fully functioning member without any supernumerary time to orientate themselves to the ward.

(b) Issues relating to the preparation of preceptors and support for their role.

The emergent themes from the Queensland Nursing Council study with regard to preparation of preceptors were that preceptor training was generally desirable but not mandatory and formal routine evaluation of preceptors was uncommon. Further it was noted that preceptors had little awareness of the aims and objectives of the graduate transition process and had little or no input into planning and evaluation of their role.

The thematic analysis of *Invitation for Submissions* also revealed that the lack of appropriately trained preceptors to facilitate the transition of new graduates into the workforce was an issue (over 25 per cent of the submissions considered this an issue). Further, the participants who forwarded submissions to the Taskforce noted that there was no allocation of supernumerary time for either the new graduate or the preceptor. It was generally stated by participants in these three studies (Queensland Nursing Council, Postal Survey, *Invitation for Submissions*) that funding support of the transition process is essential to enable new graduates to receive the level of support they deserve and need.

The Steering Committee recognised that the current figures informing the Casemix Funding Model used in South Australia and Victoria may not be accurate with regard to transition support.

It also recognised that the Queensland Health Hospital Funding Model has two major components – variable and fixed. The variable component includes grants for infrastructure, teaching, research, special services and high cost outliers. To date teaching grants for first year graduate nurses appear to be allocated into General Revenue and not specifically to graduate transition support. A review of the actual costs of funding transition support in the Queensland context was seen as an appropriate and sound initiative. It is recommended:

Recommendation 19

That a review of funding graduate transition support be undertaken to inform the Casemix funding model. The review should include costs of funding for back-fill of preceptors and supernumerary costs of placing new graduates in locations where they are required to undertake a more advanced role such as in small rural health facilities. The review should be based upon the Queensland Nursing Council Position Statement on Transition Support Processes for Beginning Level Nurses.

Recommendation 20

That the funding for new graduates be quarantined to ensure funding for new graduate support processes that meet the standards in the Queensland Nursing Council (QNC) position statement.

The Expert Working Group – Undergraduate/Graduate Transition Support particularly discussed and supported the *Queensland Health Indigenous Workforce Management Strategy*, and the Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN) with regard to the recruitment and retention of Indigenous Nurses in Queensland Health. It is recommended:

Recommendation 21

That specific aspects from the Queensland Health Indigenous Workforce Management Strategy which relate to nursing need to be implemented particularly those related to the requirements of transition support appropriate to the cultural needs of Indigenous Nurses.

4.2.3 Recruitment of the Nursing Workforce

Issues that arose from the Expert Working Group — Best Practice Model for Recruitment relating to the general recruitment of nurses included advertising restrictions, ineffectiveness of Staff Search services for Level 2 and above, cost of relocation to rural areas and access to education and training.

The Expert Working Group – Best Practice Model for Recruitment, collected data via Structured Telephone Interview Survey and utilised this data as a basis for development of the *Best Practice Method of Recruitment* (Figure A 5, Appendix 1). The draft model was presented to the participants in the statewide focus groups for their consideration. The model provides an overview of recommended recruitment processes and was positively received by participating nurses. The model was recommended to the Steering Committee. The Steering Committee determined that to implement the model as a basis for recruitment, a Project Officer with appropriate expertise and experience would need to be appointed to expedite further development of the

model and it's subsequent implementation. The Steering Committee highlighted the need to recognise that the implementation of this model will have implications for current Queensland Health policy in areas such as advertising. It is recommended:

Recommendation 22 *That a project be funded by Queensland Health to further develop and implement the Best Practice Model for Recruitment (developed by the Taskforce) in partnership with Health Service Districts according to specific nursing requirements.*

Recommendation 23 *That Queensland Health redesigns the current central process of recruitment in liaison with key stakeholders to adopt the Best Practice Model of Recruitment as the approach for recruiting nurses.*

When presented with the proposed *Best Practice Model for Recruitment,* participants in the statewide workshops identified that principles of merit were not being applied in selection processes. There was the perception that the current career structure was being eroded due to lack of integrity of appointment processes. The participants also believed that both nurses and non-nurses were not adhering to the principles. In many cases where the processes were conducted, it was perceived that the successful applicant had been previously selected. It is recommended:

Recommendation 24 *That, as a matter of urgency, Queensland Health educates staff on the processes to ensure principles of meritorious selection are adhered to.*

4.2.4 Retention of the nursing workforce

Data collected from the statewide focus groups suggested nurses in rural and remote locations are specifically disadvantaged with regard to accessing information technology. They noted the negative impact this has on communication, management practices, access to education and training, and particularly, the use of Telemedicine. Many participants stated that they did not have access to email or to Queensland Health Information Network (QHiN). The participants believed that improved access to information technology would provide greater potential for flexible delivery of education programs to help overcome problems of distance. The availability of appropriate information technology would assist both clinical practice and education in the workplace thus improving the retention of nurses in rural and remote areas of Queensland. It is recommended:

Recommendation 25 *That Queensland Health assesses the availability of computer software and hardware for nurses in rural and remote locations.*

The Supply Strategies Expert Working Group focussed on the numbers and qualifications of nurses to meet current and future workforce needs. To project these figures, analysis of the nursing workforce is necessary. The recommended framework (Health Workforce Planning and Analysis

Unit – Appendix 3) was successfully applied to the midwifery workforce and the expert working group recognised that this framework could provide workforce analysis for other areas in nursing. The Steering Committee highlighted the fact that other workforce analyses methodologies had been unsuccessfully applied to nursing in Queensland Health. In contrast, the recommended framework had proven successful in its application. It is recommended:

Recommendation 26

That "Queensland Health's Nursing Workforce – A framework for evaluating the balance between supply and demand" be applied generally and as a priority to systematically evaluate nursing workforce requirements for cardiac, aged care, rural and community nursing (Appendix 3).

Recommendation 27

That the Health Advisory Unit (Nursing) adopt a role in assessing the analysis of workforce planning data on an annual basis for the formulation of strategic advice and direction.

Focus group questions concerning the term "Model of Care" were intentionally designed by the Flexible Work Environment Expert Working Group. Because of the relationship of this concept to the planning of nursing allocations and workloads the expert working groups believed that clarification of nurses' understanding of the term was required. Overall there was general confusion by nurses about the meaning of "Models of Care". The view was clearly expressed that this concept had not been articulated well to clinicians and meant different things to different people. Focus group participants also indicated that patterns of patient care delivery were often based on historical practice and did not match changing models of care. In addition, the Expert Working Group – Flexible Work Environment noted that this term was used for the calculation of nursing staff requirements for the future. The Flexible Work Environment Expert Working Group specified that clarification of the meaning of this term would be paramount in assisting nurses to plan future staffing requirements and also in managing clinical units in a manner which was congruent to the model of care. It is recommended:

Recommendation 28

That Queensland Health clearly articulates the meanings of the "Model of Care" that forms the basis for service delivery and that appropriate education for employees is provided and is implemented in the workplace.

The Flexible Work Environment Expert Working Group highlighted there are no standardised guidelines in Queensland Health for the management of nursing resources. The stress of coping with heavy workloads was a consistent theme from the statewide focus groups and the *Invitation for Submissions.* The expert working group determined that the development of a business planning model to include measures relating to workloads, skill mix, patient dependency and the training and development needs of nursing staff is a priority. The model could be applied routinely to assess current staffing levels and to calculate projected workload staffing requirements. It was claimed in *Invitation for Submissions* that staffing levels have not changed in response to the changing health care environment of decreasing length of patient stay and increasing activity. Recent management initiatives

such as performance management, change management, and clinical teaching activities were identified through data collection as factors that increased workloads. It was highlighted that no means exist to effectively analyse staffing level requirements for Queensland Health. The implementation of standardised models such as Hours Per Patient Day (HPPD) was seen by nurses as not recognising the complexities and variations in clinical practice settings. The development of Health Service District based forums was seen as a complimentary strategy to the proposed business planning model by the Flexible Work Environment Expert Working Group and that forums should be implemented to constructively address identified workload pressures and strategies at a district level. It is recommended:

Recommendation 29 *That Queensland Health funds the development of a Business Planning Model to provide a method of determining appropriate long term nursing staffing levels necessary to meet specific service requirements.*

Recommendation 30 *That Health Service District based forums are developed to monitor nursing workloads and associated issues and develop strategies in response in accordance with Queensland Health Certified Agreement No.3 (1998).*

4.2.5 Recruitment and Retention of the Nursing Workforce

Based on information from participants at the Corporate Approach to Nursing Workshop and the Expert Working Group – Corporate Approach to Nursing, highlighted the requirement for the strategic direction for nursing to be facilitated at the corporate level in line with the strategic direction of Queensland Health. The Health Advisory Unit (Nursing) is currently staffed by the Principal Nursing Advisor and one Project Officer with shared access to administrative support. The nursing workforce comprises 42.4 per cent of the Queensland Health workforce and an even greater percentage of the clinical workforce. In order to facilitate a strategic direction and provide advice, the expert working group articulated that the Unit would need to be appropriately resourced. The consultation process at the statewide workshops supported the development of a strategic direction for nursing. It was articulated by the expert working group and supported in the consultation phase that an expanded Health Advisory Unit (Nursing) would be well equipped to address a range of issues raised in the Taskforce such as facilitation of building closer links with the tertiary sector; coordinating reference groups to address processes such as performance management systems statewide; and other projects. The expert working group also highlighted that Health Advisory Unit (Nursing) input into policy decisions should be consistent with the strategic direction of Queensland Health. It is recommended:

Recommendation 31 *That in line with the strategic direction of Queensland Health, the current Health Advisory Unit (Nursing) is responsible for:*

- *the development of the strategic direction and vision for nursing in Queensland Health*

- *raising the profile of nursing*
- *providing professional leadership*
- *developing an approach that is consistent with Queensland Health organisational solutions*
- *other issues identified in this report.*

Recommendation 32 *That the Health Advisory Unit (Nursing) be resourced and structured appropriately so that it can fulfil its responsibilities (Appendix 2).*

Recommendation 33 *That in the formation of policies affecting nursing, input from the Health Advisory Unit (Nursing) or its designated representative is sought.*

Within the consultative process (statewide workshops) nurses stated that communication was not always effective and the development of a Queensland wide strategy would be useful. Communication to nurses (particularly beyond the South East corner) was perceived as problematic. A tangible example was evidenced in the statewide workshop survey where there was a demonstrated knowledge deficit of family friendly policies (Queensland Health). The access of nurses to information technology was varied and ranged from no access to good facilities. There was a high percentage of responses in the statewide workshop surveys (93 per cent of all responses) that feedback to nurses' suggestions about organisational issues was inconsistent if given at all. Sixty percent of Level 3 nurses responded that they were given little input into organisational decision making for their facility and that decisions were imposed with little or no consultation. The Corporate Approach Expert Working Group noted these issues and determined that the development of a corporate communication strategy could assist to improve statewide communication and raise awareness throughout Queensland Health of the importance of communication.

Participants in the Statewide Workshops indicated that barriers to effective performance management processes included the lack of training for supervisors, the lack of consistent application of the processes, the fact that the processes were often viewed as punitive, the competing demands of Level 3 nurse workloads which left insufficient time for performance management activities, and the inconsistent use of performance management tools across organisations. A major theme in *Invitation for Submissions* was the need to develop a coordinated statewide approach to nursing staff development and the requirement for linkage with performance development review. The Corporate Approach to Nursing Expert Working Group identified that it would be appropriate to examine these factors and the system/s currently in place for nursing by establishing a reference group to develop appropriate strategies in response. It is recommended:

Recommendation 34 *That the Health Advisory Unit (Nursing) develops a communication strategy to disseminate and receive relevant and necessary information to and from nurses throughout Queensland Health.*

Recommendation 35

That a reference group predominantly of nurses be established by the Health Advisory Unit (Nursing) to review the application of the performance management system for nurses.

Statewide Workshop surveys and *Invitation for Submissions* highlighted workplace problems such as restrictive management practices, closed management styles, and the need to support the development of nursing leadership. The Corporate Approach to Nursing Expert Working Group determined that this could be facilitated by large health facilities linking with small health facilities. These links would encompass peer support, guidance and direction for less experienced staff and other initiatives. The Steering Committee highlighted that supporting, promoting and developing nursing leadership and the associated appropriate structures will be critical to career succession planning and promotion of the nursing profession. It is recommended:

Recommendation 36

That zonal managers facilitate the further development of models of nursing leadership to extend from larger health services to smaller health services.

In all Taskforce findings the lack of organisational support for smaller health services was highlighted. Information provided indicated the difficulty in obtaining advice and the lack of resources to develop organisational initiatives. The Corporate Approach to Nursing Expert Working Group noted from the data collected that the identified shortfalls often resulted in problems such as lack of access to award entitlements (Time Off In Lieu – TOIL, overtime provisions), absence of induction programs and limited training opportunities for nurses. The Flexible Work Environment Expert Working Group considered non application of these entitlements impacted negatively on nurses and negated the establishment of family friendly work practices.

The Steering Committee highlighted that as well as support extending from the larger to smaller health services, the zonal model could also facilitate the level of support. It is recommended:

Recommendation 37

That mechanisms be developed to provide support services through partnerships which would extend from large health services to smaller health services. Examples of support are:

- *mentorship*
- *orientation and induction processes*
- *human resource management and industrial relations*
- *training and professional development opportunities*
- *leave relief*
- *quality management*
- *research*
- *information technology support*
- *coordination of undergraduate clinical placement.*

Participants in the Statewide Workshops indicated that they supported patient dependency systems when applied effectively. However, many difficulties were identified with patient dependency systems such as

lack of benchmarking, the poor utilisation of the systems generally to prospectively manage, the unreliability of data, and lack of feedback to staff about patient dependency results. Reasons stated for ineffectiveness of the system ranged from ineffective implementation, lack of facilitation of the system, lack of staff time to accurately input data and lack of recognition or value of nursing clinical judgement in relation to staff/patient needs. The Flexible Working Environment Expert Working Group analysed data collected through *Invitation for Submissions* and focus groups and concluded that such systems required appropriate management support for data to be reliable and utilised appropriately. It is recommended:

Recommendation 38

That the management of patient dependency systems is further developed to ensure data consistency, interrater reliability, feedback mechanisms, and the recognition that nursing clinical judgement is a valid method by which to further assess appropriateness of staffing levels for workload requirements.

Recommendation 39

That patient dependency standards be developed in conjunction with a statewide education program to promote understanding and reliability of the data generated.

Recommendation 40

That the development, implementation and viability of patient dependency occurs for services currently without such systems.

Invitation for Submissions, Statewide Focus Groups, and Workshop Surveys indicated the need for the development of improved management practices throughout nursing. Examples of deficits given included restrictive and closed management practices. The Steering Committee considered effective leadership would be promoted through aligning Executive Nursing Positions to other District Executive services. This could be facilitated through appropriate salary packaging. The Steering Committee indicated that this initiative would place appropriate value on the role. It is recommended:

Recommendation 41

That the terms and conditions of appointment to Executive Nursing positions be aligned to the terms and conditions of District Executive Services and that negotiation occurs with appropriate parties to implement the alignment.

Invitation for Submissions, Statewide Workshop Surveys, and focus group data consistently detailed many examples of how Level 3, Level 4 and Level 5 roles have broadened. Organisational changes such as accrual based accounting and associated budget devolution, facility management of rural and remote health services, and changes in the nursing career structure were frequently cited. The Steering Committee recognised that there are existent resultant anomalies within each level/ role. To appropriately assess the situation a review including benchmarking would need to occur. The review will involve negotiations with the Queensland Nurses' Union and other key stakeholders. It is recommended:

Recommendation 42

That a review of the Level 3, Level 4, and Level 5 roles be undertaken and benchmarked. The range of roles and associated responsibilities from Level 3 to Level 5 has broadened and consequently anomalies exist which will require the generic level statements to be reviewed.

A major Taskforce theme was the inadequacy of Level 3 remuneration. It was clearly stated by the focus groups, in the *Invitation for Submissions*, and the Workshop Surveys that current remuneration was a barrier to recruiting Level 2 nurses into Level 3 positions due to the prospective income reduction. It was also stated that Level 3 remuneration was inadequate for the complexity of the roles and responsibilities in a rapidly changing health care environment. Participants indicated these issues were barriers for the recruitment and retention of Level 3 nurses.

It was stated that current identified anomalies restricted applicant pools for these positions and had negative long-term impacts. The Steering Committee identified Level 3 nurses were critical in the successful management of health services due to their pivotal organisational role. The Level 3 roles encompass but are not limited to organisational reform initiatives, managing health services at the point of service delivery, and managing nursing teams. The Steering Committee identified that the lack of parity of Level 3 remuneration with other Australian States was a recruitment issue given portability and movement of expertise. It considered rectification of the identified anomalies would increase future application pools for Level 3 positions and therefore assist in attracting quality applicants. If not addressed the issues pose significant risks for the future in terms of the quality of management and clinical practices. It is recommended:

Recommendation 43

That as anomalies in the Level 3 salary have been identified immediate action be initiated to address these anomalies.

Focus group findings identified that the impact of clinical workloads and additional management duties are creating tension for nurses. The need to factor in time allowances to meet extra organisational needs was paramount. With changes to the Level 3 role the Flexible Work Environment Expert Working Group discussed the fact that Level 2 nurses were required to expand their input into management duties. The general role statements (career structure) for Level 2 nurses state: *Level 2 nurses may relieve Level 3 positions, take additional responsibility as delegated from the Clinical Nurse Consultant clearly differentiating the Level 2 role from that of the Registered Nurse. For example:*

- *Planning and coordination of ward/unit, education programs, and staff development activities.*

The general role statements for Level 3 Clinical Nurse Consultants include:

- *Assesses professional development needs of staff and co-ordinate with education programs*
- *Identifies issues requiring policy review*
- *Develops and implements relevant quality assurances programs*
- *Participates in staff selection processes*

- *Participates in orientation and other staff development activities.*

The Flexible Work Environment Expert Working Group determined that for these activities to be achieved staffing levels must be calculated accordingly. It is recommended:

Recommendation 44

That Queensland Health gives recognition to non-clinical time required for management and other activities for Level 2 and Level 3 Nurses in the determination of future staffing levels.

The Enrolled Nurse role is not currently included within the career structure. Enrolled Nurse focus group participants expressed the view that this did not promote their value as members of the nursing team or demonstrate an option for career progression. The Workshop Surveys also validated this theme. The Flexible Work Environment Expert Working Group acknowledged that this group of nurses contributed significantly to the activities of the health care team and, as such, should be represented within the current career structure. It is recommended:

Recommendation 45

That Queensland Health and the Queensland Nurses Union negotiates to incorporate the role of the Enrolled Nurse within the career structure.

Workforce analysis data indicated seven Health Service Districts experienced a nursing turnover rate of 28 per cent or higher. From a Queensland Health perspective, it can be difficult to replace skilled clinicians, particularly as most of the areas identified were in rural and remote locations. To address higher turnover rates research into causal factors would be appropriate. The Steering Committee specified that recognition of these factors would enable the implementation of appropriate strategies to address any problems. It is recommended:

Recommendation 46

That Queensland Health initiates research to investigate the reason for turnover in Health Service Districts that have an abnormally high turnover rate.

Structured Telephone Interview Survey with the Directors of Nursing indicated a lack of reimbursement for removal costs was a major disincentive for the recruitment of nurses to rural locations. The Flexible Work Environment Expert Working Group also discussed the inequities which exist between Queensland Health Nurses and agency employed Nurses in respect to travel cost reimbursement. Agency personnel are provided with air travel to working destinations in rural locations, whereas Queensland Health staff do not have the same option. The expert working group recognised that relocation costs could be considerable for nurses and a significant barrier to the recruitment of nurses to rural locations where the turnover of nurses is high. It is recommended:

Recommendation 47

That a package of reasonable relocation expenses as outlined in IRM2.3-4 be adopted for nurses moving to rural/remote locations.

The Taskforce is aware processes are being undertaken to review Public

Sector superannuation arrangements. It is understood that there will be options for improved portability of entitlements and initiatives which will generally improve superannuation uptake. Taskforce data have indicated that nurses, when compared to other occupational groups are relatively undersuperannuated. It is recommended:

Recommendation 48 *That Queensland Health supports the modification of Public Sector superannuation arrangement to ensure that QSuper meets the needs of a mobile, predominantly female workforce.*

4.3 Promote the introduction of family friendly rostering and management practices.

Generally, all taskforce expert working groups believed the ability to conduct workplace management in a way that did not impact negatively on family considerations was seen as paramount for effective recruitment and retention. The Flexible Work Environment Expert Working Group developed strategies to access information from nurses relevant to this term of reference. It recognized that the workforce has changed considerably in response to societal trends and, as a result, nurses (male and female) now balance paid employment with family responsibilities. The expert working group also recognised that nurses with family responsibilities are valued clinicians. Therefore, in order to successfully recruit and retain these employees, the ongoing facilitation of family friendly work practices are paramount.

The Flexible Working Environment Expert Working Group applied processes to collect data that related to the current status of family friendly rostering practices. Incorporated within this was the necessity to examine current management practices that impact on the work environment. The Corporate Approach to Nursing Expert Working Group noted from the data collected that the identified shortfalls often resulted in problems such as lack of access to award entitlements (TOIL, overtime provisions), absence of induction programs and limited training opportunities for nurses. Surveys completed at workshops demonstrated that nurses were generally unfamiliar with the range of existing family friendly policies and that family leave was the most significant policy discussed and accessed. Awareness of other existing policies was not evident in the responses. It is recommended:

Recommendation 49 *That Queensland Health develops processes to notify Health Service Districts of existing family friendly policies and evaluate the current uptake of these policies for the whole organisation.*

Lack of availability of extended hours childcare was highlighted in the statewide workshop surveys, *Invitation for Submissions* and the focus groups. Lack of childcare availability was seen as an impediment to flexible rostering practices. This impacted on nurses with children and other staff who worked the hours that parents with children could not, due to the unavailability of child care. The Flexible Work Environment Expert Working Group highlighted the need for Queensland Health to assess the need for childcare in order to plan strategies for the future

which align with other government initiatives. It is recommended

Recommendation 50

That Queensland Health undertakes an analysis of nurses' childcare needs within the next twelve months in line with whole of government approaches to the provision of appropriate extended hours childcare services.

Focus group participants identified the lack of application of award conditions such as overtime and TOIL. These views were also substantiated in the workshop surveys. The Flexible Work Environment Expert Working Group considered non-application of these entitlements impacted negatively on nurses and negated the establishment of family friendly work practices. It is recommended:

Recommendation 51

That Queensland Health provide information statewide about nursing award entitlements and develop strategies to monitor that these conditions are being applied.

Rostering practices were seen by many focus group participants as inflexible and inequitable. Individual and organisational issues cited included:

- problems with self rostering creating unreasonable demands by some
- perception that full time employees are disadvantaged in having to work the undesirable shifts
- requests for fatigue and study leave often unable to be met as no backfill available
- difficulties in replacement of staff in rural and remote locations
- the lack of experimentation of different shift lengths
- a lack of organisational rostering principles or guidelines.

The Flexible Work Environment Expert Working Group identified that through implementation of the proposed rostering trials a range of rostering principles could be applied. Long term rostering expertise could be further developed and principles distributed for statewide application. It was stated that innovative rostering practices could impact positively for workload management and promote family friendly workplaces. The Steering Committee recommended that six trial sites would need to be established and supported in order to cover the diversity of workplaces. The results of trials could then be recorded and distributed to health services statewide so that the nursing workforce at large could benefit from innovative practices. It is recommended:

Recommendation 52

That a project be established to trial rostering at six pilot sites representing rural, remote, metropolitan and provincial settings.

A consistent theme to the Ministerial Taskforce was the variance in standards of accommodation. Problems identified include that accommodation for nurses is of a low standard, caters for one person only and nurses in some instances have to share accommodation. Respondents to telephone surveys indicated that the quality and shortage

of accommodation was a barrier to recruitment and also created retention problems. The Flexible Working Environment Expert Working Group observed that there was not a consistent standard of accommodation for nurses employed by Queensland Health. It is recommended:

Recommendation 53 *That a standard for new/replacement remote area nurse accommodation be finalised and adopted for rural and remote locations.*

4.4 Aged care

The expert working group identified the management of aged care in Queensland Health is fragmented. The residential aged care reforms, the ageing population, chronic disease management, enhanced technology, capitation of residential care bed numbers and Queensland Health capital works programs are some of the key factors impacting on the provision and extent of nursing care services to older people in Queensland. A strategic direction for aged care in Queensland, developed in consultation with key stakeholders including nurses, should lead to services, which are integrated, complementary, flexible and potentially beneficial to older clients.

It is imperative that the nursing care needs of those accessing aged-care services are understood and the skill mix of regulated and unregulated staff is appropriate and adequate to meet accepted quality standards. It is recommended:

Recommendation 54 *That Queensland Health sets a strategic direction for aged care service delivery which includes the role and functions of Registered, Enrolled Nurses, and Assistants in Nursing*.

Expert representatives from a wide range of aged care settings highlighted that aged care nursing is not limited to care delivered in residential aged care facilities but extends from the community through acute care, rehabilitation and specialist aged care settings. A lack of aged care nursing specialists available to advise and consult across these settings and integrate services appropriately was noted. Appointing designated Clinical Nurse Consultant/s who function across Districts and/or Zones, and specialise in aged care nursing, would address this issue. It is recommended:

Recommendation 55 *That within each Queensland Health Zone aged care nursing specialists are available to provide consultancy and mentorship in respect to aged care service delivery.*

Prior to commencement of the Ministerial Taskforce a proposal for the establishment of a 'Professorial Chair in Clinical Nursing Practice — Gerontological Nursing' was submitted to Queensland Health. This was a joint proposal from Queensland University of Technology (QUT) and Princess Alexandra Hospital (PAH). As highlighted in the proposal, there is an identified nursing need 'to provide a focus for clinical practice, research and education in the gerontological area'. It is recommended:

Recommendation 56 *That in accordance with Recommendation Sixteen, Queensland Health investigates the establishment of a Queensland Professor of Gerontology Nursing aimed at improving the health status of older people in Queensland.*

Analysis of the aged care workforce in Queensland Health revealed that very few nurses working in this area pursued relevant professional development. The focus on the nursing needs of older clients in tertiary nursing programs was found to be minimal. It was also noted there has been little encouragement for nurses to pursue specialist education in the area of aged care. The increased percentage of aged clients across all health settings highlights the need to enhance the professional education opportunities for nurses caring for older clients. It is recommended:

Recommendation 57 *That Queensland Health establishes and promotes continuing professional education opportunities for nurses caring for older clients.*

4.5 Mental health

To facilitate the provision of mental health service workforce planning data has demonstrated that there needs to be an increase in the number of endorsed mental health nurses employed by Queensland Health. The expert working group identified several strategies to facilitate this (Appendix 14). It is recommended:

Recommendation 58 *The Queensland Health endorses the current proposals for the development of the mental health nursing workforce capability as raised within the Mental Health Expert Working Group (Appendix 14). The proposals include:*

- *the provision of Mental Health nursing scholarships funded at two thirds of the cost of university fees by Queensland Health*
- *the allocation of a Project Officer to progress specific nursing issues.*

4.6 Overarching recommendation

Recommendations accepted by the Minister will require a coordinated and planned approach. The Steering Committee specified that an implementation process was essential and that the Minister for Health should be provided with timely progress reports on the implementation.

It was agreed that a coordinated implementation process would be best achieved through a representative group to include but not be restricted to key nursing stakeholders and zonal managers (given the newly implemented corporate structure for Queensland Health). It is recommended:

Recommendation 59

That a representative group which includes key nursing stakeholders and zonal managers be established to plan and implement the recommendations of the Taskforce and further that this group report six monthly to the Minister on the progress of such implementation.

BIBLIOGRAPHY

Congress of Aboriginal and Torres Strait Islander Nurses, 1998. *Recommendations to develop strategies for the recruitment and retention of indigenous peoples in nursing.*

Denzin, N. 1989. *The Research Act,* McGraw Hill, New York.

Donovan Research, 1998 *Research to assist the development of a campaign to promote nursing as a career, Western Australia*.

Gooloo, W., Sloan, F.A. and Davis, C.K., Eds, 1996. Nursing *Staff in Hospitals and Nursing Homes: Is it adequate*? Institute of Medicine. National Academy Press, Washington, D.C.

Hegney, D., Pearson, A. & McCarthy, A., 1997. *The Role and Function of the Rural Nurse in Australia*, Royal College of Nursing Australia, Canberra.

Holloway, I. & Wheller, S. 1996. *Qualitative Research for Nurses*, Blackwell Science, London.

Queensland Health, 1995 *Final Report — Ministerial Taskforce on Remote Area Nursing in Queensland.*

Queensland Health, 1999 *Our Jobs. Our Health. Our Future – Queensland Health Indigenous Workforce Management Strategy*.

Roberts, K. & Taylor, B., 1998. *Nursing Research Processes: an Australian Perspective*, Nelson ITP, Melbourne.

Sandelowski, M. 1986. The problem of rigour in qualitative research, *Advances in Nursing Science* 8(3), pp27-37.

Appendix 1 Data analysis and results

1.1 Taskforce findings – demographic data

1.1.1 Current regulated and unregulated workforce profile—Queensland Health

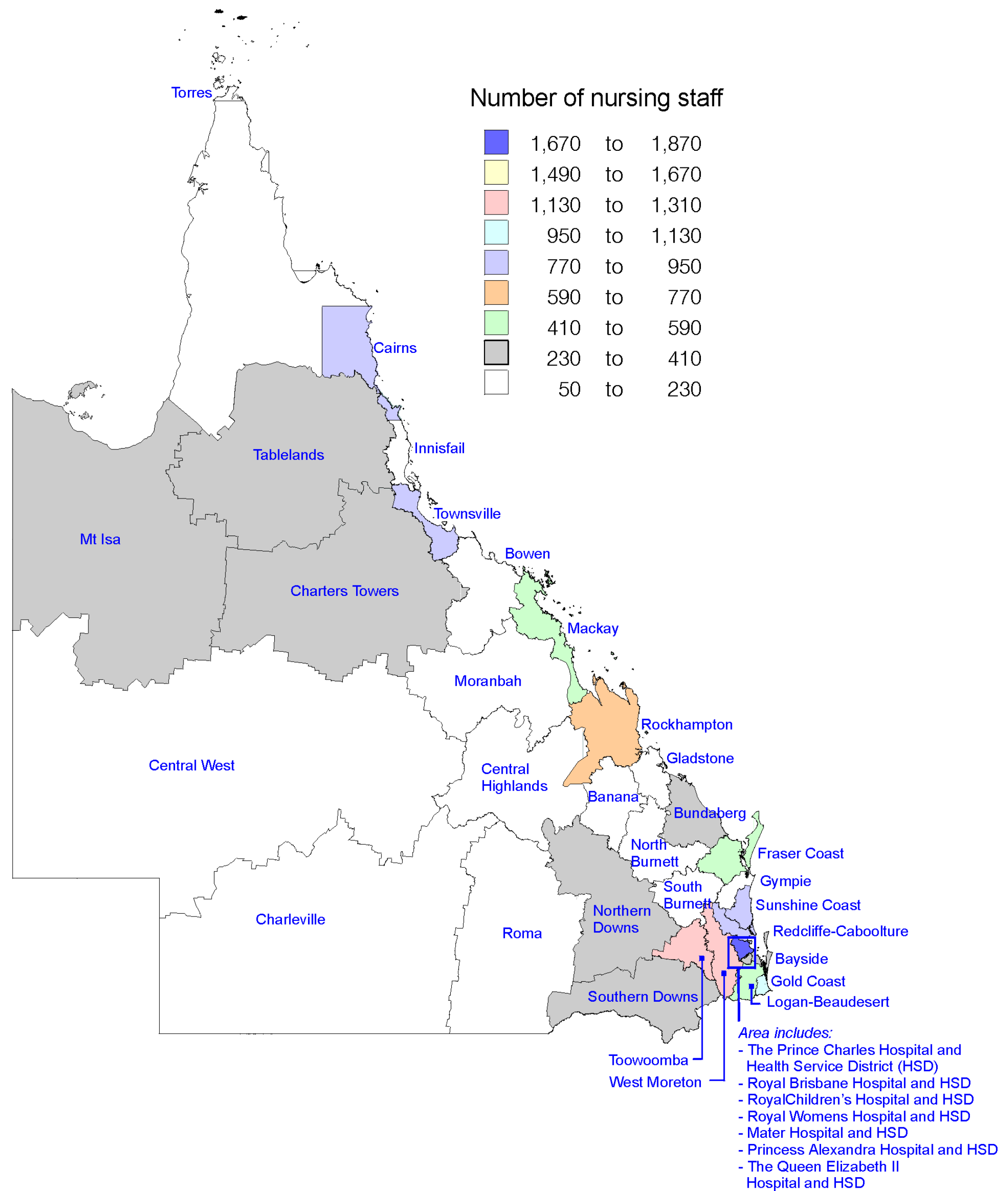
Queensland Health employed 20,653 nurses (regulated and unregulated) in September 1998. This was 42.4 per cent of the total Queensland Health Workforce and 65 per cent of all nurses employed in Queensland. The largest groups employed by Queensland Health are Level 1 registered nurses (Table A 1).

Table A 1 *Workforce component*

Nursing workforce component			*Number*
RN			16101
	Level 1	10775	
	Level 2	3638	
	Level 3	1392	
	Level 4	107	
	Level 5	189	
EN			3408
AIN			1144
Total			*20653*

Geographically, approximately 60 per cent of the Queensland Health nursing workforce are located in South East Queensland (Figure A 1).

Figure A 1 *Geographic distribution of Queensland Health's nursing workforce, (by Health Service District) September 1998*



Age Profile

The average age of regulated nurses together with Assistants in Nursing (unregulated) employed by Queensland Health is 39.3 years. The average age of the workforce is represented in Table A 2.

Table A 2 *Average Age of Workforce*

Workforce component	*Average age (years)*
RN	38.7
EN	41.5
AIN	41.8
All nursing staff	39.3
Overall average age for nursing	*41.5*

The age profile of students enrolled in undergraduate pre-registration courses in Queensland is changing. Enrolment of year 12 students in the courses is gradually decreasing, while the percentage of late entry applicants is increasing (Table A 3). This will significantly increase the age profile of graduates and consequently, the age profile of nurses in Queensland Health.

Table A 3 *Comparison of first preferences for late entry and Year 12 applicants*

Year	*1994*	*1995*	*1996*	*1997*	*1998*
% of year 12 applicants who placed BN (pre-reg) as first preference	3.4	2.6	2.6	2.4	2.0
% of late-entry applicants who placed BN (pre-reg) as first preference	3.3	3.7	3.9	3.6	3.9

The age distribution of the nursing workforce for enrolled and registered nurses are depicted (Figures A 2 and A 3). It is anticipated that if age trends for enrolments at undergraduate level for nursing continue that the average ages of these categories of nurse will also continue to rise and therefore result in an older nursing workforce.

Figure A 2 *Age distribution of registered nurse workforce, September 1998*

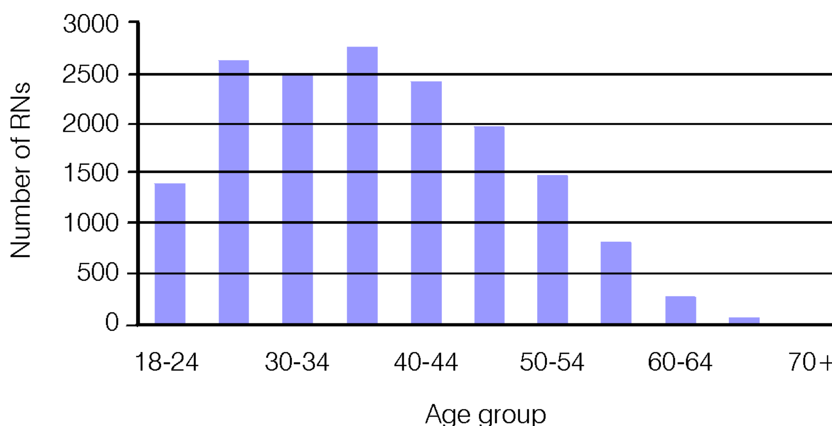
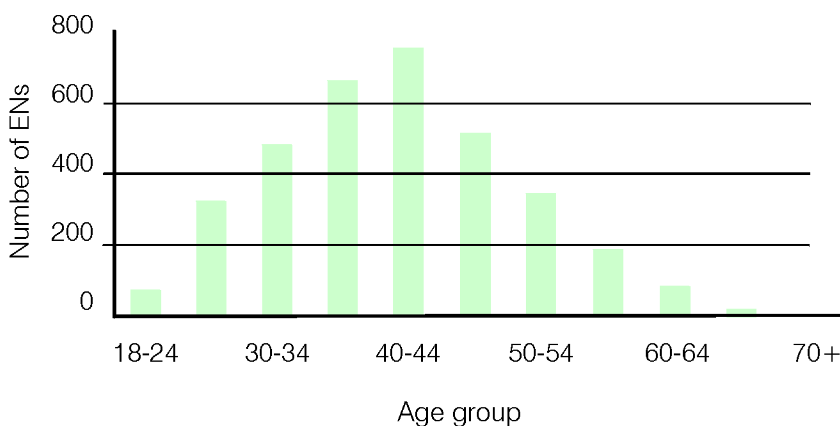


Figure A 3 *Age distribution of the enrolled nurse workforce, September 1998*



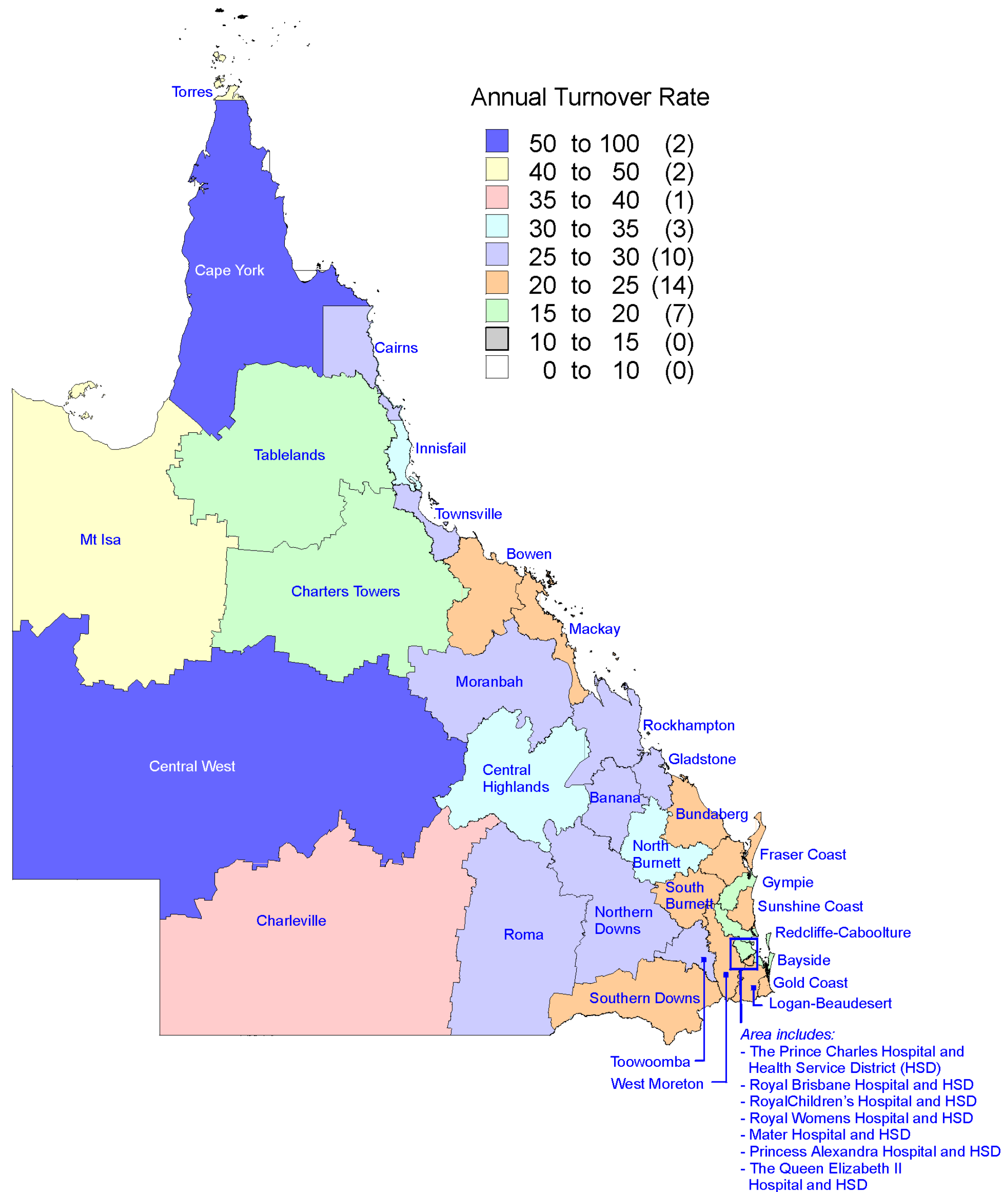
1.1.2 Turnover

The definition used for the calculation of turnover is —

> *Turnover is the annual percentage separation rate of a nominated group of employees obtained by expressing the number of net leavers over the original number of employees at the start of the year.*

The average Health Service District turnover per annum for Queensland Health for all categories of permanent staff from 1994-1998 was 20 per cent. The average annual turnover for nursing across all districts was 20.2 per cent (Appendix 13). There are seven Districts that exceed this average considerably, with turnover rates ranging from 28 per cent to over 50 per cent. The turnover rates are depicted in Figure A 4.

Figure A 4 *Average Annual District Turnover Rates for Queensland Health's Nursing Workforce (1994-1998)*



Age profile — relationship to turnover

Age is an important factor in turnover. The turnover rate for the 20 - 29 age group is higher than the Queensland Health average at 31.8 per cent, and the rate for the 40-59 age group is lower at 12.5 per cent (Table A 4).

Table A 4 *Nursing turnover rate related to age group*

Age group	*2-29*	*30-39*	*40-49*	*50-59*	*60-69*
%Turnover	31.8%	19.6%	12.4%	12.7%	25%

The turnover for nurses in their first year of service is higher than the average at 35.1 per cent (Table A 5). This decreases to 27.6 per cent in the second year of service, and continues to drop with increasing length of service.

Table A 5 *Percentage of nursing turnover for years of service*

Years of Service	*0 – 1*	*1 – 2*	*2 – 3*	*3 – 4*	*4 – 5*
%Turnover	35.1%	27.6%	23%	20.1%	17.9%
Years of Service	*5 – 6*	*6 – 7*	*7 – 8*	*8 – 9*	*9 - 10*
%Turnover	14.9%	13.1%	12.4%	11.5%	11.3%

There is little difference identified in turnover between males and females (Appendix 13).

1.1.3 The changing profile of Queensland Health's nursing workforce, 1993-1998

The profile of the nursing workforce within Queensland Health is changing. From 1993-1996 nursing staff numbers increased by 4.9 per cent per annum, which could be attributed to the growth of health services in response to demographic trends. The growth in nursing mirrored the growth of the total Queensland Health workforce in that time. From 1997-1998 growth decreased to 2.5 per cent per annum. Current trends indicate that growth could decrease to 1 per cent or less over the next two years. Traditionally, zero growth means employment of nurses occurs on the basis of vacant positions that are created from resignations.

The growth has not been uniform across the State and tends to correspond to changes in service provision in response to demographic changes.

Age profile

The nursing workforce is aging but broadly at the same rate as other staff in Queensland Health. Generally, the age profile of all categories of nursing is rising (Table A 6).

Table A 6 *Changing age profiles*

Component	*Year*		*% change in average age*
	1993	*1998*	
RN	36.6	38.7	5.7%
EN	37.4	41.5	11%
AIN	41.1	41.8	1.7%
All Nursing	37.0	39.3	6.2%
All QH staff	38.5	41.5	7.8%

The reasons identified for the changing age profile are attributed to:

1. Older nurses are not retiring: Preliminary Taskforce data indicate that nurses are not superannuated as well as other categories of Queensland Health staff. Low interest rates and the lifting of the retirement age have also impacted and reduced the retirement rate.

2. New graduates are getting older: This is due to the changing profiles of persons enrolled in pre-registration undergraduate nursing courses in Queensland (Table A 3).

Implications of the changing age profile of the nursing workforce in the future will be the drop in the numbers of Registered Nurses under the age of 30. Currently 26 per cent of the Registered Nurse workforce is aged 30 or below, however the figure is anticipated to fall dramatically over the next ten years to between 15 and 18 percent. Currently, most Registered Nurses tend to do advanced nursing study before they turn 30, that is, there may be implications for the supply of the future nursing specialist workforce. A workforce that is diverse in terms of age is less sensitive to external economic factors than one that is not diverse.

1.2 Taskforce findings — qualitative and quantitative data

The qualitative and quantitative data collected through Taskforce initiatives were analysed and forwarded to the relevant expert working groups to form the basis for the Taskforce's recommendations. In total five hundred nurses contributed via expert working group membership, structured telephone interview surveys, workshops, and surveys. In addition *Invitation for Submissions* attracted a wide range of submissions which represented large groups of nurses. The Steering Committee was satisfied that data were collected from a well spread selection of sites throughout the State (Figure 2, page 24).

1.2.1 Structured telephone interview survey of Directors of Nursing (Queensland Health)

(a) Data analysis

Data from the telephone interview surveys of thirty-six Directors of Nursing were thematically analysed. Thematic analysis was chosen as the aim was to find related categories, concepts, and similar meanings within the data (Holloway & Wheller, 1996) and there was no preconceived theoretical framework.

(b) Results

Recruiting processes identified by nurses varied. Many facilities used the Queensland Health recruiting mechanism (Staff Search) with varying degrees of success ranging from limited to successful. Many other recruitment strategies were also used. These included the use of agency nursing staff on short term contracts (usually a three month contract including agency fees and return air fares), word of mouth, advertising in local publications, nurses presenting at the facility seeking employment and secondment from other facilities.

When asked whether processes used were effective, fifty-four percent

(54 per cent) of participants stated that the processes they used were effective. These processes were a combination of those outlined above. Forty-six percent of participants stated that processes were not effective for the following reasons:

- advertising restrictions and poor responses to advertisements
- delays in advertising time
- staff search services were ineffective for the recruitment of Level 2 nurses and above
- many instances of new employees staying only three months.

Major issues cited as barriers to recruiting nurses to the areas surveyed included:

- the lack of accommodation available or a lack of suitable accommodation. The accommodation was perceived as either of a poor standard or unsuitable for more than one person, as it did not cater for partners or children
- the lack of training or education opportunities
- the lack of child care facilities
- no reimbursement for removal costs was a major disincentive
- the view that many rural areas are isolated yet do not receive any reimbursement (such as the remote area nurse package) to assist with increased cost of living in these areas
- risks to personal safety in some areas
- distance from larger centres
- inappropriate advertising.

The strategies identified by more than twenty-five percent of those surveyed to improve recruitment included:

- creative advertising (nursing journals, internet, more marketing of nursing, flexibility to advertise more successfully)
- provision of accommodation which meets an appropriate standard
- reimbursement of travel expenses
- relocation allowances
- child care provision
- recognition of rural and remote nursing as a specialty
- wider application of incentives such as the remote area nursing package
- recruitment of graduate nurses with appropriate transition support.

1.2.2 Workshops / focus groups / interviews

Corporate approach to nursing in Queensland Health

(a) Data analysis

Data from the workshop generated from the discussion were thematically analysed. Thematic analysis was chosen as the aim was to find related

categories, concepts, and similar meanings within the data (Holloway & Wheller 1996) and there was no preconceived theoretical framework.

(b) Results

From the raw data, emergent themes were developed by the Corporate Approach Expert Working Group to present for consultation at the ten statewide workshops. The workshops focussed on three topic areas: geographical issues, training and development and performance management.

The predominant themes raised under these headings were analysed by the expert working group and draft recommendations developed. The recommendations were then presented for validation at the statewide workshops. The Steering Committee adopted the proposed recommendation for inclusion in the Final Report.

Clinical placement of undergraduate nursing students — workshop

(a) Data analysis

The data generated by consensus of each of the small groups in the workshop were presented to the Undergraduate / Graduate Transition Support Expert Working Group for analysis and incorporation into the recommendations to the Steering Committee.

(b) Results

Participants worked in small groups to identify:

1. Positive initiatives for clinical placements of undergraduate nursing students currently occurring.
2. Four priority areas requiring further development for the future (Table A 7).

Table A 7 *Clinical placement workshop results*

Positive initiatives	*Areas for development*
Universities and health care providers • Increasing collaboration • Consistent liaison between the two — in some cases joint coordination of clinical placement that results in improving communication. *Models of student supervision* • Preceptorship model • Facilitation by clinicians (includes remuneration) • Consistent facilitation standards	• Inadequate levels of preceptor training and preparation of clinicians for student clinical placements • Inadequate length of clinical placements • The gap between university and health service provider expectations • Inconsistency of accommodation provision in rural and remote areas Inconsistency in remuneration for hospital based facilitators • No funding support for undergraduate nurses to undertake clinical experience in rural and remote locations

• Facilitation by clinicians as a professional development opportunity through recognition of the preceptor role (curriculum vitae) *Clinical placements* • Flexible shifts • Variety of clinical exposure *Student* • Free board in some rural areas for duration of clinical placement. • Overview on the Internet.	• No central data bank to indicate clinical placement availability • Disparity between the tertiary sector and health care providers • The impact of downsizing of hospitals on staff which affects undergraduate pre-enrolment students • The need for one contact to organise clinical placement in both tertiary and health care organisations • The need for integration of clinical placement objectives with the clinical environment • High workloads, low nursing staff numbers and the demands of clinical placement • Student overlap from different tertiary organisations • Lack of consistency of facilitation • No planning meetings between tertiary sectors and providers • Aged care and mental health – the need to value these specialties by placing students in second and third year.

Statewide workshops — focus groups

Focus group data were analysed and major themes identified within the topic areas. The major themes and sub themes were:

Workload

There were both positive and negative factors impacting on workload identified by the participants. Positive factors were the calibre of management including visible, participative management exhibiting strong leadership skills; the provision of adequate staffing levels with an appropriate skill mix; worker-friendly rostering systems; off line time for training and staff development; quarantining funds to ensure staff education and adequate equipment for patient care. Staff issues included appropriate skills mix; team personality mix and dynamics; and collaboration between disciplines.

Negative factors identified by the participants related to workload included:

- non-supportive management which does not communicate effectively and does not seek staff input; rostering and leave practices which do not provide backfill from pool staff and which fail to provide the appropriate skill mix and staffing levels; lack of clear

direction from management or a strategic plan; management which discourages TOIL, recreational and study leave and payment for overtime

- insensitive patient acuity systems which result in constant redeployment, do not allow for training and staff development time, do not accommodate emergency situations or unpredictable workloads and fail to recognise the amount of paper work some nurses must take home
- non nursing duties including non essential administrative tasks, cleaning and moving equipment
- lack of equipment and resources including physical, financial, staff and the rigors of the rural environment
- inequities in the career structure which do not reward Level 3 and Level 5 nurses (rural and remote) particularly for their level of responsibility and the degree of knowledge required for their positions
- community expectations especially in rural areas of constantly being on call
- impact on family life of inflexible rostering and leave arrangements
- workplace health and safety issues especially issues of staff security.

The major themes that arose from the participant data with regard to strategies to manage workload included:

Current strategies included:

- regular staff meetings designed to allow team building, problem solving, staff input into management and clinical issues
- supportive measures such as effective performance management, work practice reviews, visible and supportive management were identified.

Other workload management strategies included:

- working longer hours, just cope, deploy staff to areas of perceived higher need and unpaid overtime
- the allocation and quarantining of human, financial and material resources to optimise workloads, rostering arrangements that ensure a client focus, including the maintenance of adequate pool staff for backfill and supply of adequate administrative support
- the review of practices to address leave, overtime and TOIL issues, in addition to investigating flexible shift times and job sharing arrangements
- a clear organisational policy and procedures for workload management
- the introduction of two way communication processes and participative management styles to develop policies and benchmarking tools

- the introduction of information technology which allow the representation of current trends and future needs; computerised rostering systems; adaptation of current patient acuity systems to increase their sensitivity to workloads.

Rostering practices

The majority of participants indicated that they believed that there were often many strategies that could be implemented to improve current rostering practices.

(i) The themes which emerged from the participant data relating to poor rostering practices included:

Individual issues

- the perception that full time employees are disadvantaged in having to work the more undesirable shifts
- that self rostering results in unreasonable demands by some
- that requests for fatigue and study leave often unable to be met as no backfill available
- that no childcare rostering provisions or facilities provided to accommodate shift workers with families
- the difficulty in being able to please everybody in smaller facilities without putting unfair pressure on less experienced staff.

Organisational issues

- that ideal rosters on a personal level can compromise organisational requirements regarding skill mix and adequate staff for night duty
- the lack of replacement of staff on sick leave and difficulty in replacement of staff working in rural and remote locations.

(ii) The themes that became apparent from the analysis of participant data with relationship to strategies that would overcome unsatisfactory rostering practices were:

Individual issues

- education for nursing staff about rostering principles.

Organisational issues

- clear guidelines on a unit basis for requests and skill mix requirements per shift
- computer generated rosters linked to predicted patient acuity, with supernumery time built in for staff development and management of any additional portfolios
- provision of affordable child care on site
- consultation with staff regarding rostering guidelines and the development of clear policies
- broader implementation of strategies such as flexible shifts and hours for example job sharing, ten hour night duty.

Patient dependency

Participants were asked to identify the effectiveness of patient dependency systems in their health facility. There were both positive and negative responses to this question.

The themes that emerged relating to the unreliability of patient dependency systems included:

- that current systems were reactive rather than proactive, failed to accurately roster staff on shifts, and did not accommodate emergency situations. Skill mix information was not factored in and time spent in administrative and non nursing duties such as entering the patient dependency data, answering phones, stocktaking or orienting casual staff to the ward, were not considered
- that data entered was frequently not accurate
- that current systems in use did not suit all areas. For example, the systems cannot be applied currently for the special requirements of community settings and were not weighted to account for high dependence areas in general wards such as palliative care
- that in rural areas, no patient dependency systems for staffing was used.

Rewards/opportunities and performance

Respondents were asked to comment whether rewards/opportunities should be provided by Queensland Health in relation to good performance. The areas which were identified as important were personal rewards, financial rewards and rewards available at the ward level.

(i) Personal rewards. The emergent themes were positive feedback and job satisfaction and the ability to represent the unit or organisation at forums, conferences, state reference and advisory groups.

(ii) Financial rewards. The themes included:

- adequate remuneration for level of knowledge, skill responsibility and education
- equity in award entitlements with other health professionals, adequate accommodation and conditions, incentive packages such as paid relocation expenses to rural areas.

(iii) Rewards at the ward level. These included the themes of rewarding efficient units through acknowledgement of effectiveness and not have staff deployed elsewhere as a result of budget inefficiencies .

Performance management processes

It was noted that many of the participants stated many facilities are either just developing performance management systems or have none in place. It was also noted that some facilities had well developed performance management processes. The responses related to performance management processes were either positive or negative.

Participant's views on positive performance management processes were that performance appraisal of any kind can be effective in overcoming performance issues and time management problems if both parties are committed to the principles of performance management. It was perceived as a positive affirmation of effective performance which encourages negotiation skills, promotes personal goal setting and the identification of strengths, developmental needs and opportunities.

The themes that became apparent with regard to negative aspects of performance management were that processes are often seen as punitive, focus on the negative and not rewarding those who are performing well. Those administering the process have no management training and fail to implement it properly. It is often a token acknowledgement of performance and not a priority of managers. It is frequently not done, even though it is compulsory and not followed up. Nurses also report inconsistent use of the tool across organisations and contexts (rural, remote and metropolitan contexts). Participants emphasised that for many nurses from Level 3 and above the processes had severely increased workloads and time allowance had not been factored for this.

Career structure

Participants raised both negative and positive issues related to the career structure.

The emergent themes of positive aspects of the career structure were that the existence of the career structure was positive for providing opportunities for advancement, professional recognition and increased educational support.

The themes which arose with regard to the negative aspects of the career structure were that current remuneration for Level 3 was seen as a barrier to career progression generally and inappropriate for the role responsibilities. It was stated that Level 2 nurses often would not apply for these positions due to the loss of income and the view that the role was more complex. Lack of integrity in appointment processes was highlighted as eroding the career structure. A distinct theme was the lack of recognition of the role of nurse clinicians and the reducing opportunities for career progression for this group. Many participants indicated that the career structure was being modified through fiscal strangulation. Impediments to the career structure included lack of role education, workloads and staffing levels.

Models of nursing care

Participants gave significantly diverse responses to the questions asked about models of care. They described models based on nursing theorists to models based on a geographical location. It was clear from the responses that there was no perception of a consistent Queensland Health approach and that participants were unclear about the meaning. A significant issue raised was the frustration of participants with this much used term that appeared to have a major impact particularly for staff allocation figures for redeveloping services. It was often the view of participants that this was severely disadvantageous for nurses.

Queensland Nursing Council's — Assessment against Queensland Nursing Council Standards of New Graduate Transition Support in Selected Queensland Health Care Agencies.

(a) Data analysis

The interviews and focus groups tapes were transcribed verbatim. Qualitative content analysis was undertaken manually utilising key words and key phrases to identify recurrent and major themes.

(b) Results

The emergent themes from the data analysis were related to information gathered from Directors of Nursing, preceptors and new graduates.

Directors of Nursing (DON)

The major themes identified were that:

- all of the Health Care Agencies (HCAs) had some form of a twelve-month preceptorship process in place
- some HCAs and units in HCAs had a structured theoretical and clinical experiential model of graduate transition
- the responsibility for graduate transition was generally at the division or unit level
- the preceptor preparation was, generally, desirable but not mandatory
- workforce issues such as rostering, staff and skill mix affected preceptorship and supernumery time
- preceptor support and recognition varied but was generally of a limited nature
- formal and/or routine evaluation was uncommon
- accurate costing of graduate processes was not available
- funding from government sources could not generally be accounted for.

Preceptors

The major themes identified were that:

- preceptors generally had little awareness of the aims and objectives of the graduate transition process
- with the exception of speciality units, the majority of preceptors had little or no input into planning and evaluation processes
- participation in preceptor workshops varied and was not mandatory
- selection of preceptors occurred at the unit level either by line management nomination or by volunteering
- utilisation of formal selection criteria was uncommon

- matching of preceptors and graduates was uncommon
- identification of individual learning needs varied. This process was mainly on an ad hoc basis and varied between preceptors
- preceptor's satisfaction varied with the level of involvement with and perceived 'ownership' of the graduates, the culture of HCAs and/or unit; and workplace and workforce issues
- in most instances, preceptors were involved in graduate appraisal
- most preceptors believed that they had little support or acknowledgement of their role
- most preceptors acknowledged that graduates at the completion of the process were confident and competent but could not say whether this was because of the process
- the majority of preceptors believed that the role produced an increase in their workload and stress level for which they received only intangible benefits.

Graduates

The major themes identified were that:

- all graduates reported participation in some form of transition process and preceptor
- a high level of support from senior nursing personnel was seen as integral to the graduate transition process being perceived as a positive experience. However, this occurred only sporadically
- workplace, workforce and personality issues negatively affected the level of support
- negativity between hospital and university educated staff is still apparent
- graduates expressed the opinion that when the preceptor process worked it was a positive transition into the workforce
- graduate feedback and appraisal varied significantly between and within HCAs. In some instances, there were no feedback or appraisal mechanisms in place
- whilst the majority of graduates felt they had some role in evaluation of the process it was of a diverse nature and the ability to influence change was perceived as minimal
- the perception of some graduates in some HCAs was that the graduate transition process was mainly rhetoric.

Analysis of the data indicates that in the majority of the health care agencies visited, the processes currently in place were not perceived to be effective methods of integrating new graduates into the workforce.

The health care agencies and individual units where the transition process was seen to be effective were characterised by:

- a supportive, nurturing culture

- involvement in and ownership of the process throughout the organisation
- central coordination and responsibility for a structured process
- formal policies to support the preceptor process especially rostering and preceptor support
- a planned process of evaluation to inform change and provide valid outcome measures.

1.2.3 Surveys

Statewide workshop surveys

(a) Data analysis

Quantitative Data from these surveys were analysed quantitatively and descriptive statistics were generated. Qualitative data from the open ended questions were thematically analysed for emergent themes. Emergent themes were considered to be significant if more than twenty-five percent of respondents identified this as an issue. Thematic analysis was considered appropriate as no preconceived theoretical framework had been developed.

(b) Results

All participants in the statewide workshops were invited to complete the survey. The results were analysed by entering the numbers of yes or no responses for the relevant levels. Comments were analysed and recorded if the rate of response was greater than twenty-five per cent of total responses.

Demographic data

The award employment level of nurses in the study is outlined in Table A 8.

Table A 8 *Category of nurse (n = 201)*

Employment level	*Number*	*%*
Enrolled	25	12.4
RN Level 1	20	10
RN Level 2	25	12.4
RN Level 3	85	42
RN Level 4	20	10
RN Level 5	26	13

Rural, remote, provincial and metropolitan classification

193 nurses indicated the geographical location of the Queensland Health facility in which they are currently employed. The majority of

nurses in this survey indicate they work in metropolitan areas (n = 75; 39 per cent). 58 nurses (30 per cent) indicate they are employed in provincial areas, 36 (19 per cent) nominate they work in rural areas and 24 (12 per cent) regard themselves as remote area nurses. 11 further participants are unsure of their rural, remote or metropolitan classification.

Category of health service

Nurses were asked about the type of Queensland Health facility in which they are employed. 198 nurses responded to this question, with 162 (82 per cent) of these employed in hospital settings; 22 (11 per cent) working in community settings; 9 (5 per cent) working in aged care and 5 (3 per cent) employed in health centres.

Qualitative data

Respondents were asked survey questions related to the level of organisational support they receive in the course of their employment; management styles within Queensland Health and their opinion of the current career structure. They were invited to provide further comment regarding survey items or any additional factors they believe would contribute to the future direction of nursing within Queensland Health.

Organisational support – training and staff development

Nurses were asked whether they had a mentor or support person with whom to discuss professional pursuits. Two thirds of nurses indicate they have some form of professional support, however the responses illustrate that Level 1 and Level 2 nurses have less formal or informal professional support within the organisation than Level 4 and Level 5 nurses in particular. Table A 9 outlines positive responses to this question.

Table A 9 *Availability of mentor or support person (n = 201)*

Level of nurse	*Number*	*% of level*	*% of total*
Enrolled nurse	15	60	7.5
Level 1 RN	11	55	5.5
Level 2 RN	11	44	5.5
Level 3 RN	58	68	29
Level 4 RN	16	80	8
Level 5 RN	22	85	11
Total	133		66.5

Organisational support – skill use

Respondents were asked whether their skills are being used in an effective and appropriate manner. 109 nurses (54 per cent) believe the organisation makes an effective use of their skills. The breakdown of positive perception of skill use by level appears in Table A 10.

This indicates that Enrolled Nurses and Level 3 Registered Nurses believe their skills are not used as appropriately as other levels, Level 3 nurses citing workloads as the major barrier to skill development.

Table A 10 *Appropriate use of skills (n = 201)**

Level of nurse	*Number*	*% of level*
Enrolled nurse	14	56
Level 1 RN	15	75
Level 2 RN	16	64
Level 3 RN	44	52
Level 4 RN	13	65
Level 5 RN	17	65
Total	109	

*(not all participants responded to this question)

Organisational support – skills acquisition

Participants in the survey were asked whether they believed they possess appropriate skills for their current role and whether the organisation has provided them with support and training to function effectively within that role. 136 (68 per cent) nurses responded positively to this question. Table A 11 details the breakdown of these positive responses.

Table A 11 *Skill acquisition and organisational support (n = 201)**

Level of nurse	*Number*	*% of level*
Enrolled nurse	18	72
Level 1 RN	17	85
Level 2 RN	18	72
Level 3 RN	50	59
Level 4 RN	17	85
Level 5 RN	16	62
Total	136	

*(not all participants responded to this question)

Of the 32 per cent of nurses who do not believe their skills are used appropriately or who do not receive adequate organisational support to acquire skills, further analysis of the level of nurse employment related to these skills reveals common themes. For example, Enrolled Nurses cite lack of organisational support for skill development and discuss self-initiated skill acquisition. Level 2 nurses refer to a general lack of organisational training opportunities, lack of Level 3 support, the personal cost of skill development both financially and in terms of increased workload, in addition to a lack of organisational flexibility with regard to rostering. Level 3 nurses emphasise that they have received less than optimal training to perform their roles which, similar to Level 5 nurses, they attribute to the restraints of budget and workload. Level 3

nurses indicate that management training incorporating financial and informational technology components would be beneficial.

Organisational support – flexibility

144 nurses (72 per cent) believe they work in a flexible work environment. Table A 12 illustrates nurses' positive responses to this issue according to their level of employment.

Table A 12 *Flexibility of working environment (n = 201)**

Level of nurse	*Number*	*% of level*
Enrolled nurse	19	76
Level 1 RN	18	90
Level 2 RN	16	64
Level 3 RN	66	78
Level 4 RN	14	70
Level 5 RN	11	42
Total	144	

*(not all participants responded to this question)

It appears that Level 2 nurses, who carry the most clinical responsibility and Level 5 nurses, who carry the most managerial responsibility, are subject to the least flexibility in their employment. Level 2 nurses attribute this to the necessities of maintaining an adequate Level 2 presence when accounting for skill mix in rostering. Of those Level 3 nurses who believe their working environment is inflexible, 'management practices' and 'workloads' are cited as the major impediments.

The perception of flexibility is influenced by rostering practices such as shift length. Table A 13 details the responses of participants when asked whether they would like to see changes in rostering practices within their organisation.

Table A 13 *Changes in rostering practices (n = 201)**

Level of nurse	*Number*	*% of level*
Enrolled nurse	15	60
Level 1 RN	10	50
Level 2 RN	17	68
Level 3 RN	69	81
Level 4 RN	14	70
Level 5 RN	11	42
Total	136	

*(not all participants responded to this question)

The results indicate that Level 1 nurses are ambivalent regarding change to rostering practices and that Level 5 nurses are the least positive about changing current rostering practices. Of those who would like to see

changes to current practice introduced, the majority of nurses at Level 3 and below suggest that the introduction of ten hour shifts would be beneficial. The major flaw in present rostering systems identified by Level 1 nurses appears to be a lack of discussion of personal needs and a lack of organisational flexibility regarding the trialing of new rostering practices.

Management practices – family friendly policies

Nurses also nominated rostering as a dominant theme when asked if their organisation has 'family friendly policies'. The data presented in Table A 14 are positive responses to the presence of family friendly initiatives within their place of employment. These data demonstrate that over half of all nurses (52 per cent) surveyed, the majority of whom are employed at career levels subject to the difficulty of juggling shiftwork and family, do not view their organisation as having family friendly policies. Level 3 and Level 4 nurses, who are usually not shiftworkers, are the most positive regarding the presence of family friendly policies in their workplace.

Table A 14 *Family friendly policies (n = 201)**

Level of nurse	*Number*	*% of level*
Enrolled nurse	11	44
Level 1 RN	7	35
Level 2 RN	8	32
Level 3 RN	53	62
Level 4 RN	13	65
Level 5 RN	12	46
Total	104	

*(not all participants responded to this question)

Apart from rostering practices, Levels 1 to 4 inclusive highlight the lack of childcare availability as a dominant concern.

When asked if they have accessed any of the family friendly benefits available to them, 65 nurses (32 per cent) indicate they have done so as outlined in Table A 15. However, 50 per cent of the additional qualitative responses across the groups indicate a lack of understanding or awareness of such benefits, which include the Child Care Policy, Work and Family Considerations Policy and the Special Responsibility Leave Policy (Queensland Health).

Table A 15 *Use of family friendly policies (n = 201)**

Level of nurse	*Number*	*% of level*
Enrolled nurse	10	40
Level 1 RN	4	20
Level 2 RN	10	40
Level 3 RN	32	38
Level 4 RN	6	30
Level 5 RN	3	12
Total	65	

*(not all participants responded to this question)

Management style – staff involvement in decision-making

Nurses were asked whether their organisation had a mechanism by which they could voice their level of satisfaction or dissatisfaction. Table A 16 outlines positive responses to this item.

Table A 16 *Mechanism for staff comment (n = 201)**

Level of nurse	*Number*	*% of level*
Enrolled nurse	21	84
Level 1 RN	15	75
Level 2 RN	17	68
Level 3 RN	67	79
Level 4 RN	20	100
Level 5 RN	24	92
Total	164	

*(not all participants responded to this question)

Of the 164 (82 per cent) nurses who responded positively, Level 4 nurses and Level 5 nurses are the most likely to be aware of such mechanisms, whilst Levels 2 and 1 are the least likely. 52 per cent of Level 2 comments indicate that even if they are aware of such procedures, there was frequently no response when they were accessed, and that if there was a response it was often negative. Additional Level 3 comment reinforces nurses' views that employee feedback is not valued by the organisation. Furthermore, when asked whether this mechanism is satisfactory or effective, many respondents at Level 3 and below indicate it is not. This is demonstrated by the poor positive responses to this question outlined in Table A 17 at this level of employment. The failure of organisations to provide feedback is perceived as the major weakness of mechanisms for staff comment.

Table A 17 *Mechanism for staff comment as satisfactory/effective (n = 201)**

Level of nurse	*Number*	*% of level*
Enrolled nurse	11	44
Level 1 RN	8	40
Level 2 RN	6	24
Level 3 RN	36	42
Level 4 RN	13	65
Level 5 RN	15	58
Total	89	

*(not all participants responded to this question)

Staff input into clinical decision making is viewed more favourably, as outlined by Table A 18.

Table A 18 *Staff input into clinical decision making – positive responses (n = 201)**

Level of nurse	*Number*	*% of level*
Enrolled nurse	16	64
Level 1 RN	15	75
Level 2 RN	19	76
Level 3 RN	68	80
Level 4 RN	18	90
Level 5 RN	25	96
Total	161	

*(not all participants responded to this question)

This table also demonstrates that the higher the level of employment, the more positive the perception of employee input into clinical decision-making. Additional comment by Enrolled Nurses indicates that whilst they have some input into clinical decision making processes, decisions are made regardless of their input. Similarly, 43 per cent of those Level 3 nurses who report limited involvement in such processes argue that nursing input regarding clinical decisions is disregarded.

With regard to organisational decision making, Table A 19 demonstrates that 50 per cent of Level 2 nurses are ambivalent regarding their role in this process, and Level 1 and Enrolled Nurses believe they have a limited role. Enrolled Nurse responses highlight a 'top-down' approach to organisational decision making which does not include them, whilst Level 3 nurses responding negatively to this item reiterate that their input into the organisational decision making process is either disregarded or over-ridden. Furthermore, whilst many nurses (n = 111; 55 per cent) do receive some feedback about their input, 93 per cent of additional comment indicates that even if feedback is given, it is frequently not consistent.

Table A 19 *Staff input into organisational decision making – positive responses (n = 201)**

Level of nurse	*Number*	*% of level*
Enrolled nurse	9	36
Level 1 RN	3	15
Level 2 RN	13	52
Level 3 RN	51	60
Level 4 RN	17	85
Level 5 RN	21	81
Total	114	

*(not all participants responded to this question)

Career structure

The data indicate that only 36 per cent of respondents overall, and nurses at Level 3, 1 and below, do not believe the current career structure addresses their career objectives, as indicated by the pattern of positive responses in Table A 20.

Table A 20 *Career structure meets career objectives – positive responses (n = 201)**

Level of nurse	*Number*	*% of level*
Enrolled nurse	6	24
Level 1 RN	7	35
Level 2 RN	12	48
Level 3 RN	25	29
Level 4 RN	9	45
Level 5 RN	14	54
Total	73	

*(not all participants responded to this question)

Additional enrolled nurse comments emphasise the need for Enrolled Nurses to be included in the career structure and recognised as a valuable member of the team. Level 1 nurses highlight the lack of advancement opportunities within the career structure as problematic, whilst Level 2 nurses cite part time status, lack of Level 3 remuneration and a general lack of opportunity to advance as the major impediments to progression through the career structure. 91 per cent of negative Level 3 comment in relation to the career structure focuses upon inadequate remuneration, lack of advancement opportunity, role erosion and heavy workloads. Level 4 responses discussed erosion of the career structure and the lack of a clinical career path.

Postal survey — graduate transition support

(a) Data analysis

Data were analysed using quantitative analysis and descriptive statistics were generated.

(b) Results — quantitative data from graduate questionnaire

The nurses participating in the study were asked to identify the type of health institution where they are currently employed (Table A 21) and the type of health institution where they undertook their graduate transition experience.

Table A 21 *Type of health institutions in which the respondents in the studyare currently employed.*

Employment Setting	*1998 (graduate experience)* n	%	*1999 (current employment)* n	%
Community	1	2.6	Nil	nil
Hospital	37	94.9	38	97.4
Private Sector	1	2.6	1	2.6
Total	39	100	39	100

Respondents were also asked to identify the number of placements that occurred during their graduate transition experience. Seventeen (43.6

per cent) of the respondents stated that they had only one placement, approximately thirty-one per cent (n=12) had two placements, six nurses (15.4 per cent) had three placements and only four nurses (10.3 per cent) experienced more than three placement.

The nurses were asked to identify the type of units where they were employed during their graduate transition experience. The most common placement was in a surgical unit (including urology and orthopedic) — approximately 39 per cent (n=29). The second ranked placement was in medical units (including rehabilitation, infectious diseases, accident and emergency) with approximately 35 per cent (n=26) nurses experiencing this placement during their transition year. Other areas of placement included 9.3 per cent perioperative (operating theatre, anesthetics); 5.3 per cent medical/surgical (intensive care and so on); 5.3 per cent rural/remote; 4 per cent community (alcohol and drug, respite, palliative care and so on); and 2.7 per cent mental health.

Further information was gathered in relationship to the length of stay. It should be noted that as the a graduate transition experience is for a maximum of one year (52 weeks) that any length of stay in a unit that was more than 52 weeks has been adjusted to 52 weeks (Table A 22).

Table A 22 *Type of unit by length of stay in each unit*

*Type of unit**	*Length of stay (weeks)*		
	Average	*Minimum*	*Maximum*
Surgical	25.9	4	52
Medical	24	5	52
Perioperative	17.6	12	26
Medical/Surgical	38	16	52
Rural/Remote	52	52	52
Community	10.7	6	18
Mental Health	36	20	52

* (Due to the low response rate of 28 per cent, the reported units have been aggregated into seven categories.)

Participants were asked if they had participated in a formal new graduate program. Twenty-nine (74.4 per cent) of the respondents had participated in such a program. Those nurses who had participated in a formal program were asked to identify the length of the program. The data suggest that approximately 62 per cent of nurses undertook a program between seven to 12 months in duration.

The 29 nurses who had participated in a new graduate program were then asked to indicate the perceived benefits of the program (Table A 23).

Table A 23 *Benefits of the New Graduate Program*

Benefit	*n**	%
Good support/encouragement/feedback from preceptor	16	38.1
Well structured program	15	35.7
Good support/encouragement/feedback from other ward nurses	6	14.29
No comment	5	12.0

* (Twelve of the respondents indicated more than one benefit)

These respondents were asked to identify the non-beneficial components of the program. Table A 24 is a summary of the reported non-benefits.

Table A 24 *Non-beneficial components of the program*

Non-beneficial components	*n**	%
Lack of a structured program	10	29.4
Lack of support/encouragement/ feedback from preceptor	8	23.5
Lack of mobility	2	5.8
Too much mobility	1	2.9
No comment	13	38.2

* (Five of the respondents stated two or more non-benefits)

The respondents were asked to indicate if they believed they had received sufficient support during their graduate year. Seven (70 per cent) of the ten nurses who identified that they had not participated in a formal new graduate program stated that they had received sufficient support. Approximately ninety percent (26 of the 29 nurses) of the nurses who had participated in a formal graduate program believed that they had received support.

Those respondents who stated they did not receive sufficient support were asked to identify the areas they believed they needed more support. Of the six nurses who did not believe they had received sufficient support, four nurses (66 per cent) commented that they needed more encouragement and feedback; two (33 per cent) stated that they needed a better structured program and better vocational training.

With regard to orientation into the nursing unit, respondents were asked to identify the primary person who had taken this responsibility. Approximately 44 per cent (n=17) of nurses stated that the preceptor had undertaken this role. The next most common person to undertake orientation of the new graduate was the ward nursing staff (n=13, 33.3 per cent). The data were examined to ascertain if there were differences in the type of person orientating the new graduate to the unit for nurses who were in a formal new graduate program and those that were not (Table A 25).

Table A 25 *Key member of staff who orientated/integrated nurse into unit by participation in a formal new graduate program or no formal new graduate program.*

Staff Member	*No program*		*Formal program*		*Total*	
	n	%	n	%	n	%
Preceptor	2	20	15	52.7	17	43.6
Ward nursing staff	4	40	9	31	13	33.3
Other	2	20	2	6.9	4	10.3
Clinical nurse	1	10	2	6.9	3	7.7
CNC	1	10	1	3.4	2	5.1
Total	10	100	29	100	39	100

Additionally, the respondents were asked if they their preceptor was a registered nurse. Thirty-four (87.2 per cent) stated that this was the case. The respondents were also asked if a registered nurse preceptor was provided for each placement. Twenty-six (66.7 per cent) noted that this was the case with six (15.4 per cent) stating that they did not have a registered nurse preceptor and seven (17.9 per cent) believed that this question was not applicable.

The respondents' satisfaction with their preceptor was also determined. The data suggest that approximately thirty-three percent (n=13) were very satisfied and approximately twenty-six percent were satisfied (n=10). Only three respondents (7.7 per cent) were dissatisfied with the preceptor.

The new graduate nurses were asked to indicate the length of time they experienced in the unit before they were given a full patient load. It appears that the majority of respondents had more than two days supernumerary in the unit before been given a full patient load (Table A 26).

Table A 26 *On average, the length of time before being given responsibility of a full client/patient load.*

Length of time	*n*	%
Given full patient load from day one	5	12.8
1 day	5	12.8
2-3 days	10	25.6
4-7 days	7	17.9
More than one week	8	20.5
Varied considerably from unit to unit	4	10.3
Total	39	100.0

Night duty work was also explored with the respondents. Thirty-five (89.7 per cent) undertook night duty within six months of employment. The majority of respondents (n=28, 71.8 per cent) believed that they had been prepared for night duty.

The evaluation of performance was considered to be important and respondents were asked to state how frequently this occurred. Six

(15.4 per cent) respondents reported that they had never had an evaluation of their performance (Table A 27).

Table A 27 *How often was performance evaluated?*

How often	*n*	*%*
Monthly	1	2.6
2-3 months	4	10.3
4-6 months	7	17.9
7-12 months	2	5.1
End of each placement	17	43.6
At completion of program	2	5.1
Never	6	15.4
Total	39	100.0

The data were examined to ascertain if there were any differences between the frequency of performance evaluation and whether nurses were in a formal program (Table A 28). It appears that seventeen (58.6 per cent) of the twenty-nine nurses who participated in a formal new graduate program received an evaluation of their performance at the end of each placement compared to none of the nurses who were not in a new graduate program.

Table A 28 *How often performance was evaluated by whether the nurse participated in a formal new graduate program.*

How often	*Participated in a formal new graduate program*					
	No		*Yes*		*Total*	
	n	*%*	*n*	*%*	*n*	*%*
Monthly	1	10	0	0	1	2.6
2-3 months	1	10	3	10.3	4	10.3
4-6 months	2	20	5	17.2	7	17.9
7-12 months	1	10	1	3.4	2	5.1
End of each placement	0	0	17	58.6	17	43.6
At completion of program	2	20	0	0	2	5.1
Never	3	30	3	10.3	6	15.4
Total	10	100	29	100.0	39	100.0

Additionally for those nurses who participated in a new graduate program, the person most likely to undertake the performance evaluation was either the preceptor (n=10, 34.5 per cent) or the preceptor and the Clinical Nurse Consultant (n=10, 34.5 per cent). For those nurses who were not enrolled in a formal program, the person undertaking the evaluation varied between the Clinical Nurse Consultant (n=3, 30 per cent) or 'other' (n=3, 30 per cent).

The respondents were asked if they believed that university education prepared them for clinical work. Twenty-five (64.1 per cent) respondents stated that it did not. These respondents were asked to identify the areas which required further preparation whilst at university.

The majority (n=20, 51.3 per cent) stated that they needed more practical training.

With regard to current education being undertaken at the time of the study, only nine (23.1 per cent) nurses were not at present undertaking any education program (Table A 29).

Table A 29 *Further education presently being undertaken.*

Further education	*n*	%
Hospital inservice	12	30.8
Tertiary	11	28.2
None	9	23.1
No comment	7	17.9
Total	39	100.0

The respondents were also asked if they were paying off a Higher Education Contribution Scheme (HECS) debt. Thirty (76.9 per cent) stated that they were. With regard to how this HECS debt would influence further study, eighteen (46.2 per cent) believed that it would not and twelve (30.8 per cent) stated that it would (nine nurses did not answer yes or no to this question).

1.2.4 Invitation for submissions

(a) Data analysis

The submissions were thematically analysed and a summary of emergent themes complied (those with a response rate greater than twenty-five percent). The data were analysed according to the two main categories of the invitations — barriers to recruitment and retention and strategies for recruitment and retention.

(b) Results

A total of 92 submissions (53 from rural/remote locations, 39 from metropolitan locations) were received. These submissions ranged from a small number of individual contributions to submissions representing whole nursing services in hospitals, professional and industrial organisations. It was noted that one submission received was developed by the Queensland Nurses Union on behalf of 15,100 members employed by Queensland Health.

Data from the *Invitation for Submissions* related mostly to barriers of recruitment and retention and the strategies needed to improve nursing recruitment and retention.

Barriers to recruitment and retention

The major themes were :

- lack of appropriately trained preceptors to facilitate the transition of new graduates into the workplace; no allocation of supernumerary time for either the preceptor or the new graduate
- salary inequities within the nursing career structure which do not account for the skill, knowledge and further study required to advance along the career structure and which are a significant disincentive to career progression — this was emphasised at Level 3
- role stress caused by mandatory non-nursing duties in addition to full clinical loads, inaccurate patient dependency tools and lack of relieving staff
- funding incongruent with casemix and patient dependencies
- restrictive management practices such as inflexible rostering, denial of State Assisted Research and Study leave (SARAS) and discouragement of attendance at inservice due to budgetary restrictions
- the financial burden of further study
- closed management styles maintained by untrained managers
- the stress of coping with heavy workloads.

Strategies to improve nursing recruitment and retention

Emergent themes were:

- the development of partnerships and consultation between universities and health service providers to facilitate relevant higher learning and undergraduate nursing training
- a coordinated statewide approach to all forms of nursing training, the monitoring of nursing staff development which is maintained and funded by Queensland Health and linked to performance review of health service managers and employees
- quarantining of funds for nursing training and nursing staff development

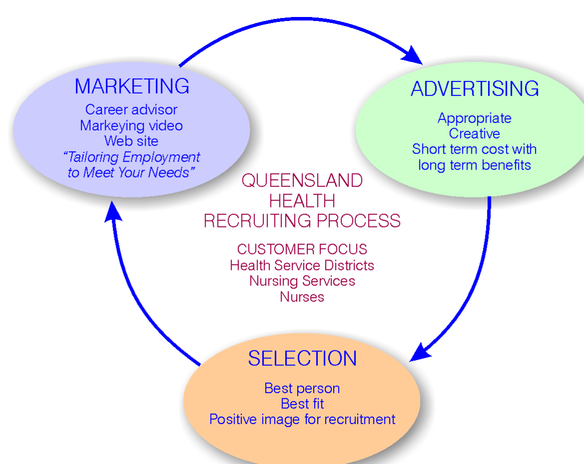
  alternative and creative education options for clinical nursing education in rural areas
- development of sensitive patient acuity systems
- a bonding/scholarship system to subsidise further nursing study in return for a guaranteed and defined term of employment for undergraduate, transition and postgraduate nurses.

5.2.5 Expert working groups

Best practice model for recruitment

The Best Practice Expert Working Group members analysed information collected from the telephone surveys. Based on this analysis the expert working group developed a best practice model for recruitment. The model was presented at the Queensland-wide workshops for validation, and modifications were made as specified by participants (Figure A 5). Strategies for marketing, advertising, selection processes, and career advice were developed with the model.

Figure A 5 *Best practice model of recruitment*



Marketing

A marketing strategy for nursing needs within Queensland Health needs to be developed in conjunction with the Marketing and Communication Unit and managed in partnership with Health Service Districts. Strategies for marketing should include but not be limited to the :

- production of a video for broad distribution to market nursing in Queensland Health as a rewarding career opportunity
- promotion of the opportunities which exist to gain clinical experience which are only possible as a Queensland Health employee, e.g. six months metropolitan nursing, six months indigenous nursing — "Tailoring Employment to Meet Your Needs"
- development of internet/intranet (QHiN) sites to market employment opportunities.

Advertising strategies included:

- the advertising salary and superannuation entitlements separately
- a review of current advertising strategies and their effectiveness, for example. Thursday advertising, content of advertisements, and anomalies of advertising executive nursing positions on Thursday (not commensurate with other executive positions)
- the development of advertisements for nursing positions with expert nursing advice as well as a HRM focus.

Selection processes

- developing a policy for Queensland Health which provides guidelines for the provision of references for nurses
- facilitating recruitment through being timely and responsive to Health Service District needs
- providing information about career options within Queensland Health following a failed employment application
- need to develop knowledge, skill, or ability, and appeal process information
- auditing appointment processes against the Public Sector Management principles to measure the integrity of the process
- providing education targeted at selection processes for relevant nursing personnel throughout Queensland Health.

Career advisory service strategies included:

- coordinating an annual open day for the promotion of nursing in Queensland Health as a career option
- the streamlining the processes so Health Service Districts inform Staff Search of new graduate numbers for the following year as early as possible — students should know their employment arrangements well in advance
- providing direct assistance to health services having difficulty in attracting graduate nurses (rural/remote locations)
- promoting to nursing students the potential for and validity of recruitment during undergraduate clinical placements
- reviewing the appropriateness of the current key selection criteria for recruiting new graduates into nursing
- basing undergraduate recruitment performance indicators on a whole of Queensland approach
- educating students about job selection processes, eg. selection of preferences which will promote early placement in Queensland Health employment.

Undergraduate/graduate transition support

The expert working group identified areas to be considered by the Ministerial Taskforce. These were:

Undergraduate education

- careers advice
- curriculum content
- clinical experience — duration and content, both within the laboratory and the field
- clinical credibility in areas where teaching takes place – laboratory and facilitation.

Clinical placements of undergraduates

- content
- quality
- time of placement
- inadequate planning for placements in tertiary institutions and institutions.

Transition support for new graduate registered nurses

- preceptorship
- beginning practitioner competency.

Relationship of health service providers to tertiary sector

- collaborative health education including
  - joint appointments
  - Clinical Chairs in Nursing
  - Clinical schools
- course advisory
- streamlining liaison/administration arrangements between universities and clinical agencies.

The expert working group reviewed the report "Research to assist the development of a campaign to promote nursing as a career" (Donovan Research, Western Australia, 1998). Findings indicated that nursing was perceived as:

- a very low status/subservient, menial occupation, gaining no respect from the marketplace
- involving either overwork and/or shiftwork
- involving work in an unhealthy environment
- giving no opportunity or chance to use own initiative.

Brochures and booklets currently used to promote nursing as a career were seen as boring and lacking information. The expert working group found that current career advisory mechanisms in high schools:

- have inadequate promotional support
- experience difficulty in contacting nurses to appear as guest speakers in programs for students, parents and the community
- lack the ability to promote and organise work experience programs within health care institutions. This was seen as a major barrier in encouraging students to consider nursing as a career.

Liaison with various career advisory organisations throughout Queensland and interstate was conducted to determine the level of

activity in the area of nursing specifically. It was found that in:

- *high schools* — there was a lack of nurse involvement with careers guidance officers for high school students
- *universities* — good liaison existed between universities and health care institutions with regard to post-graduate careers advisory and for undergraduates completing a degree
- *post-graduate* — a lack of career advice on post graduate courses
- *tertiary entrance* — over the past five years the number of applicants choosing a pre-registration nursing course as their first preference has almost halved for Year 12 applicants.

Current literature, including academic reports, research reports, and departmental documentation and nursing publications were reviewed during the project. It was found that:

- the nursing profession needs to improve the current recruitment process of new graduates
- nursing as a profession is failing to appeal to secondary school students
- the nursing profession suffers from an inability to recruit and retain experienced nurses in the workforce.

A report from the Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN) entitled "*Recommendations to develop strategies for the recruitment and retention of Indigenous peoples in nursing*" August 1998 was reviewed. It was noted that:

> The Queensland Nursing Council *"….as part of its training and development plan, Council will undertake cultural awareness and safety training for all staff. Council will also support the inclusion of such training in all nursing courses in Queensland"*.

The expert working group noted this recommendation and supported its adoption.

The need to streamline the recruitment of new graduate nurses entering the workplace has recently been debated in numerous forums, and a need to improve the process has been identified. Queensland Health's Staff Search – Graduate Recruitment Campaign was set up in 1997, and currently coordinates graduate recruitment in some districts. The Staff Search Graduate Recruitment Campaign's objectives of service are:

1. To provide fair, economical and convenient distribution of the third year Bachelor of Nursing students graduating from Queensland and interstate universities by providing a single point of entry into the workforce for Queensland public health care facilities.
2. To provide participating health care facilities with a sufficient pool of graduates to select from, to fulfil the agreed allocated vacant Registered Nurse Level 1 positions in postgraduate clinical programs.

Wide consultation was undertaken with health care institutions within Queensland and interstate to determine current practices associated with career advice and recruitment of nurses. Research was conducted with:

- Careers Advisory Services in New South Wales, Western Australia and Victoria
- Focus Groups (Nursing Recruitment and Retention Committee).

In view of the findings, the expert working group explored the methods of selection for nursing courses. The Health Workforce Planning and Analysis Unit developed a discussion paper (Appendix 12) in relation to this issue.

The Queensland Nursing Council worked in partnership with the expert working group to conduct a project on transition support of new graduate nurses. Final recommendations of the expert working group were based on the qualitative data collected by the Taskforce, the expertise of the expert working group, the project by the Queensland Nursing Council, the literature review, and the awareness raising sessions. The project was titled "*An Assessment Against Queensland Nursing Council Standards of New Graduate Support in Selected Health Care Agencies*" (Appendix 15).

Supply strategies

The Supply Strategies Expert Working Group identified the fact that Queensland Health provides a wide range of health services to the community. To facilitate the provision of quality health care there is a need for nursing staff to be appropriately qualified.

The expert working group examined "Queensland Health's Nursing Workforce — a framework for evaluating the balance between supply and demand". This framework had been applied to midwifery on a statewide basis. It was agreed that the application of this framework to different areas within nursing was the most appropriate method of projecting future needs. Based on the expertise of the expert working group and data from the Ministerial Taskforce, four areas were prioritised. These were:

Cardiac services These services are currently changing and developing. Anecdotal evidence suggests that appropriately qualified nursing staff are difficult to recruit.

Aged care The age profile of nurses in aged care demonstrates that there is low representation of nurses in the younger age groups. Information provided to the expert working group also demonstrated a low level of gerontological specific qualifications for this group of nurses.

Rural Turnover rates for a significant number of rural areas are higher than the Queensland Health average. Nurses (rural) in focus groups highlighted the difficulty in recruiting appropriately experienced nurses.

Community The working group recognised the changes to community-focussed care. In the focus groups, the community nurses identified the fact that staffing levels had not changed in response.

The expert working group has identified other areas in nursing that will require investigation. These areas include but are not restricted to:

- paediatrics/child health/adolescent
- critical care
- oncology/haematology
- peri-operative
- renal
- palliative care
- emergency
- midwifery.

The expert working group specified that these service areas should be priorities in the application of “Queensland Health’s Nursing Workforce — A framework for evaluating the balance between supply and demand” to establish the numbers and qualifications of nurses needed to meet projected demand.

During discussions about qualifications needed to enhance the competence of the nursing workforce, the expert working group acknowledged qualitative data from the Taskforce that cited cost as a barrier to nurses accessing further work-related tertiary courses. The expert working group also noted the previous development of statewide Queensland Health nursing education programs that responded to workforce needs. The programs (Critical Care and Perioperative Nursing) were aimed at the development of a more highly skilled workforce.

The expert working group specified that where deficits in nursing staff numbers and appropriately qualified personnel existed, similar statewide programs could be developed and initiated. To demonstrate this approach, the expert working group developed the proposed *Clinical education pathway* (Figure A 6).

Figure A 6 *Clinical education pathway*

Aged care

To identify emerging issues specific to aged care, the expert working group researched and developed an issues paper (Appendix 16). The residential aged care reforms, the ageing population, chronic disease management, enhanced technology, capitation of residential care bed numbers and Queensland Health capital works program are some of the key factors impacting on the provision and extent of nursing care services to older people in Australia.

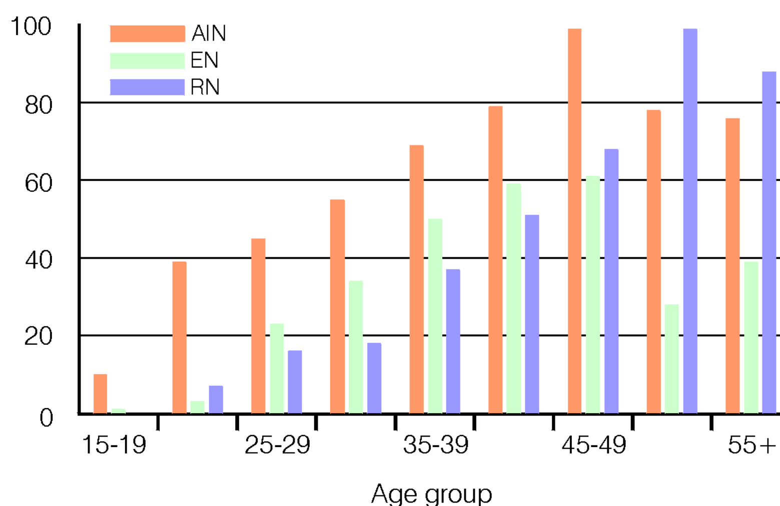
The expert working group found aged care is not limited to care in residential aged care facilities, but extends across the continuum from

community care, to acute care, rehabilitation and specialist aged-care settings. Also identified was the increased demand for professional nursing care for the aged in the community.

It is imperative that the nursing care needs of those accessing aged care services are understood and the skill mix of regulated and unregulated nursing staff is appropriate and adequate to meet accepted quality standards. A review of the literature pointed to a strong correlation between registered nurse-to–resident staff mix and quality outcomes for nursing home clients (Gooloo, Sloan and Davis, 1996).

Data accessed by the expert working group demonstrated that there is a trend towards older nurses being more significantly represented in aged care (Figure A 7). Preliminary data also highlighted the fact that nurses in aged care have not accessed postgraduate education specifically related to gerontology nursing in large numbers. Recommendations were developed on the basis of expert working group expertise and workforce analysis.

Figure A 7 *Age distribution of Queensland Health aged care nursing workforce*



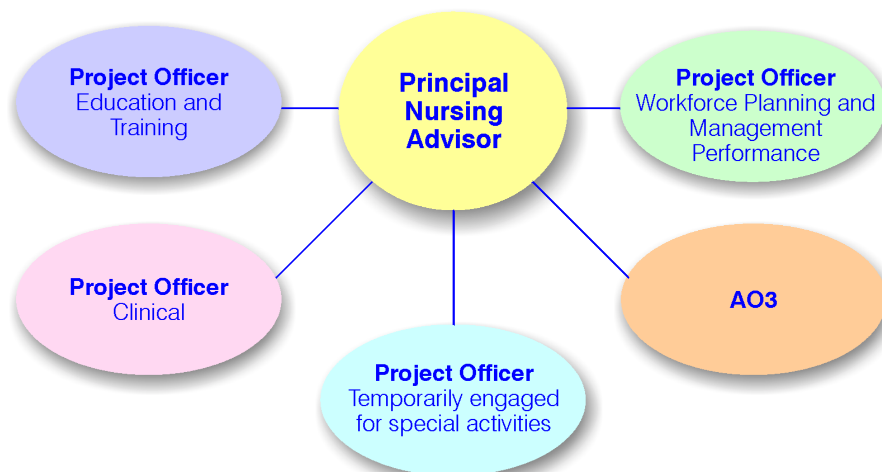
Mental health

The Mental Health Expert Working Group made use of workforce planning data developed for *The Ten Year Mental Health Strategy for Queensland* 1996. Based on this data and the expertise of the expert working group, an Issues Paper was developed. The group agreed that it would focus initially on helping nurses undertake mental health endorsement courses. The expert working group developed a report with recommendations for the Mental Health Unit (Appendix 14).

Appendix 2 Proposed Nursing Advisory Unit

Proposed arrangements — Nursing Advisory Unit
Ministerial Taskforce — Nursing Recruitment and Retention

Figure A 8 *Proposed Nursing Advisory Unit*



PROJECT OFFICER — Education and Training

- Nursing Training and Development Plan
- Facilitation Queensland Health/Tertiary Institutions Meetings
- Statewide Programs (Education Pathway)
- Queensland Health Training Advisory Committee
- Coordination of Level 2 and Level 3 Training

PROJECT OFFICER — Workforce Planning and Management Performance

- Reference Group Performance Management
- Workforce Analysis
- Human Resources and Industrial Relations Liaison in consultation with appropriate HR/IR Queensland Health staff
- Communication
- Coordinate Rostering Project

PROJECT OFFICER — Clinical

- Nursing Practice Issues
- New Initiatives (Nurse Practitioner Drugs and Poisons changes etc)
- Patient Dependency Issues (Development of Standards etc)

Appendix 3 Queensland Health's nursing workforce — a framework

Evaluating the balance between demand and supply

This document is an extract of the complete document

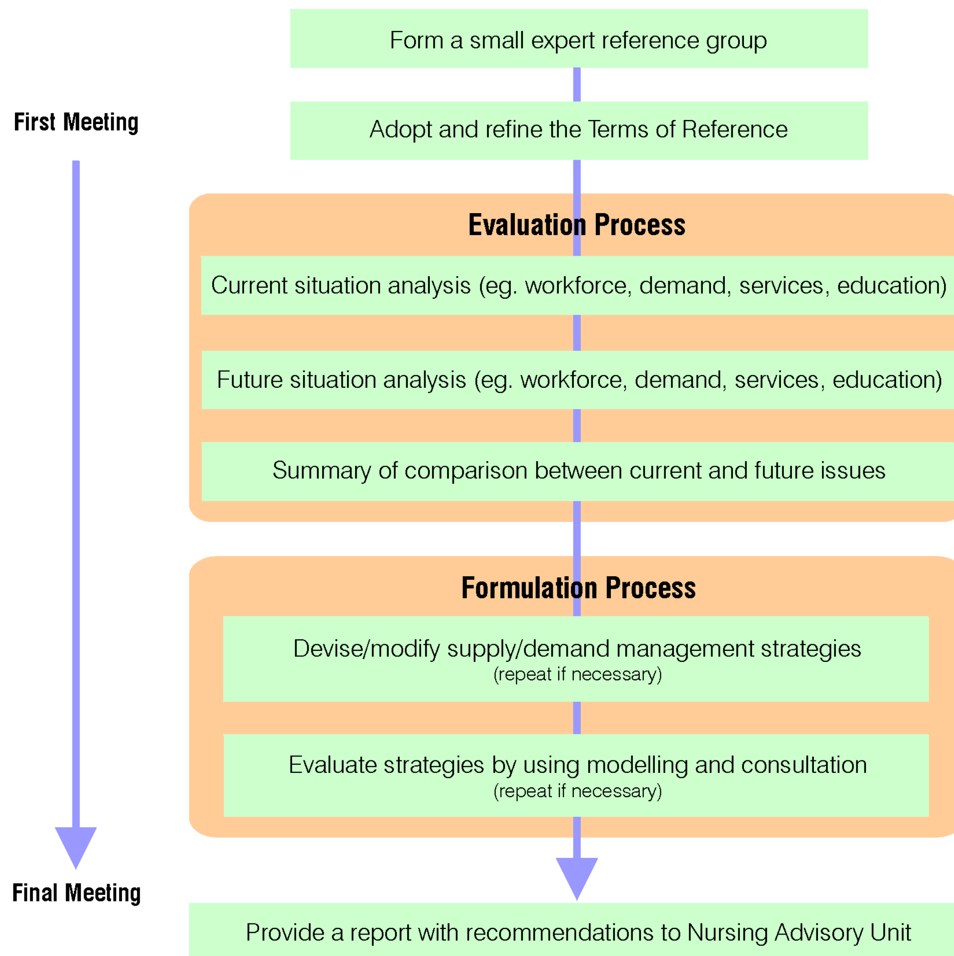
Information required for the evaluation of the supply and demand of the nursing workforce

The table below provides an indication of the types of data that may be required to implement the evaluation.

It should be noted that not all the data listed may be necessary to perform the evaluation — in some cases (depending on the workforce, urgency etc) only a subset of these data items may be required.

Demand	*Supply*	
Population (current and projected) a Size b Age c Gender d Geography e Indigenous background f Socio-economic status g Public/private **Activity data** a Hospital (DRGs or SRGs) b Community **Health services (current and future)** a Type and availability of services (models of care, levels of care) b Location (geography) c Zonal self sufficiency (referral patterns) d Benchmarks e Technology f Nursing role and role of other health professionals g Government policy/legislation Queensland Health policy **Economic status** a Inflation/interest rates **Education system** a Education numbers b Course type d Location e Cost	**Current nursing workforce** a Size (FTE and headcount) b Qualifications c Age d Gender e Geography f Indigenous background g Socio-economic status h Public/private i Vacancies **Desired/appropriate nursing workforce** a Size b Qualifications c Geography d Age e Benchmarks **Length of service** a Turnover/retention b Potential length of service **Education system** a Education numbers b Course type c Location d Cost e Entry requirements	**Reserve pool nursing service** a Size b Qualifications c Age d Gender e Geography f Indigenous background g Socio-economic status h Recency of practice **Employment system (current and future)** a Salary b Recruitment c Flexible working environment d Location e Nursing role and role of other health professionals f Government policy **Economic status** a Inflation/interest rates b Unemployment

Figure A 9 *Overview of the evaluation process in relation to overall supply strategy formulation*



Appendix 4 Expert working groups

Expert working groups — Nursing Advisory Unit
Ministerial Taskforce — Nursing Recruitment and Retention

Flexible work environment	**Corporate approach**	**Supply strategies**	**Best practice models for recruitment**
• workloads • rostering practices • patient dependency • nursing skill ratios • rewards • opportunities • career structure issues • family friendly workplaces *Chair: C. Ryan* *Project Officer: S. Cadigan* *Members* Frances Peart (ADON, Mater Adults Hospital) Anne Garrahy (CNC, Nambour Hospital) Graham Mahaffey (ADON, Toowoomba Hospital) Nigel Cumberland (Acting Manager, Employment Relations and Strategies Unit, Qld Health) Christine Houghton (CNC, Ipswich Hospital) Daniel Prentice (CNC, RBH) Lex Oliver (Professional Officer, QNU) Mary Montgomery (DON, Toowoomba Hospital) Wayne Wheeler (EN, RBH) Nick Faigniez (Senior Project Officer, HR, Qld Health)	• examine the corporate approach to nursing, nursing resource management and the nursing unit. • the development of appropriate principles for implementation of initiatives in - metropolitan - provincial - rural - remote health services • professional development and training provision • performance management statewide • salary sacrifice *Chair: L. Pyne* *Project Officer: S. Cadigan* *Members* Robyn Fox (Nurse Educator, RBH) Leanne Chandler (Education Coordinator, Rural Health Training Unit) Roslyn Henney (Acting Chair of Nursing, Div of Surgery, PAH) Sue Keleher (ADON, Mackay) Linda Jones (ADON, Rockhampton) Sandyl Kyriazis (Acting Health Centre Manager, Bamaga) Lex Oliver (Professional Officer QNU)	• numbers and qualifications of nurses to meet current and future needs • lack of appropriate skill mix data • university provision of post graduate courses and the interface with clinical practice *Chair: L. Dawson* *Project Officer: S. Cadigan* *Members* Leslie Woolf (ADON, Mt Isa Base Hospital) Haylene Grogan (Team Leader, ATSI Qld Health) Sandra Henry (Coordinator, Nurse Education, QNC) Beryl Callanan (Principal Planning Officer Nursing, PA) Kim Barry (ADON, Redcliffe Hospital) Michelle Foster (CNC, Gold Coast Hospital) Craig Slaughter (CN, RBH) Margaret Murphy (ADON, Mater Children's Hospital) Susan Mahon (Principal Project Officer, Qld Health) Fiona Hammond (Lecturer, QUT) Michael Seow (Director, Development & Training PAH) Richard Lenton (Senior Project Officer Health Workforce Planning & Analysis -Qld Health)	• undergraduate • post graduate • marketing • advertising • timely filling of positions • appropriately qualified nurses for positions *Chair: V. Tuckett* *Project Officer: S. Cadigan* *Members* Trudi Bowles (CNC, Gold Coast) Graham Wilkinson (ADON, Ipswich) Robynne Kent (ADON PAH) Serita Saba (Lecturer, ACU) Noela Baigrie (DON, Jimbolunga Nursing Centre) Lex Oliver (Professional Officer, QNU) Laurel McCarthy (District Manager, Cape York) Hamish Jeffery (CNC, RBH) John Buckby (Business Development Manager, Technical Coordination and Support Resource Management Unit, Qld Health)

Undergraduate / graduate transition support	Research	Aged care	Mental health
• undergraduate education transition support for new graduates • clinical placements • relationship of health service provider to tertiary sector *Chair: D. Hegney* *Project Officer: J. Sprenger* *Members* Jim O'Dempsey (Executive Officer, QNC) Lex Oliver (Professional Officer, QNU) Elizabeth Davies (Head, School of Nursing, ACU) Karen Stolz-Higgins (Head, School of Nursing and Health Studies, Central Qld University) Anne McMurray (Head, School of Nursing, Griffith University) Kim Usher (Head, Dept Nursing Science, James Cook Uni) Helen Edwards (Head, School of Nursing, QUT) Ros Reilly (Head, Dept of Nursing, USQ) Cheryl Burns (DON, PCH) Alison Heel (Staff Development Educator, PAH) Jenny Vakararawa (Visiting Fellow, RBH) Paul Kachel (DON, Gold Coast Hospital) Jacky Flynn (Director of Women's Health Services, Mater Mothers) Michele McHugh (Deputy Executive Director, PHAQ) Sue Price (Executive Director, Eventide Nursing Home) Colleen Davis (DON, Carindale Nursing Home) Sally Goold (Chair, Congress of CATSIN) Jennene Greenhill (Director, Research and Development Center for Innovation) Bronwyn Quinn (DON, Community Nursing Services) Richard Lenton (Senior Project Officer, Health Workforce Planning & Analysis Unit – Qld Health)	• turnover rates - standard calculation • existing vacancy levels • recruitment delays • staff stability - identify high risk areas • $ cost of turnover • staff retention parameters • methodology to investigate the Queensland context i.e. focus groups, small sample survey, comparative analysis, submissions from nursing groups *Chair: S. Norrie* *Project Officer: S. Cadigan* *Members* Sue Norrie (Principal Nursing Advisor) Mary Montgomery (DON, Toowoomba Hospital) Geoff Carse (Manager, Health Workforce Planning and Analysis, Qld Health) Jim O'Dempsey (Executive Officer, QNC) Desley Hegney (Professor of Rural Nursing Toowoomba Health Services and USQ) Danny Youlden (Senior Project Officer, Health Workforce Planning & Analysis Unit) Richard Lenton (Senior Project Officer, Health Workforce Planning and Analysis, Qld Health)	*Chair : S. Norrie* *Project Officer: K.Pearson* *Members* Sue Price (DON, Eventide) Kerry Hayes (DON, Moreton Bay) Gay Ballen (CNC, Roma) Ursula Kellet (Lecturer, Gerontology) Maureen Spence Thomas (CNC, PAH) Cathy James (DON, Community) Maria Ignatievsky (Director, Aged and Community Care Branch) Donna Bowman (Proxy, ANZCMHN) Lyn Dempster (Team Leader, Pine Rivers Community) Robyn Daskin (Aged Care Queensland) Jo Root (Team Leader, Aged Care Reform)	*Chair : S. Norrie* *Project Officer: S.Cadigan* *Members* Therese Fitzgerald (Chair of Nursing, PAH) Lisa Fawcett (Nursing Director, RBH) Tanya Yegdich (Proxy, RBH) Damon Atzeni (CNC, Bayside) Keryn Fenton (ADON, PCH) Liz Osborne (ADON, Logan/ Beaudesert) Margaret McAllister (Griffith University) John Quinn (Secretary, ANZCMHN) Beverley Schumacher (Team Leader, Nambour Hospital) Don Gorman (Associate Professor, Nursing, USQ) Carol Swendson (DON, Wolston Park) Ian Hay (Nurse Educator, Wolston Park) Linda Solomons (ADON, Gold Coast Hospital) Michelle Denton (Team Leader, Forensic) Ruth Elder (Lecturer, QUT) Craig Moffitt (ADON, Cairns) Judy McDonnell (DON, Southern Downs Mental Health Unit) Julie Crosbie (ADON, Mental Health, Rockhampton) Jacqueline Couani (Team Leader, Kirwan Rehabilitation Unit) Barbara Hayes (Professor in Nursing, James Cook University) Mark Quadrell (Registered Nurse, Psychiatric Unit, Townsville General Hospital) Michael Seow (Director, Development and Training, PAH)

Appendix 5 Telephone interviews — DONs

Health Service		
Winton	Georgetown	Atherton
Thursday Island	Townsville	Theodore
Normanton	Warwick	Bundaberg
Springsure	Hervey Bay	Kingaroy
Nambour	Baillie Henderson	Toowoomba
Mt Isa	PCH Community	Doomadgee
Cunnamulla	Kowanyama	Roma
Longreach	Richmond	Tully
Ingham	Cooktown	Dysart
Cairns	Ayr	Monto
Yepoon	Logan	Gympie
Tara	Caboolture	Esk

1. Could you outline the methods utilised at (insert) health service for the recruitment of nurses?

2. Is this an effective process?

3. Could you indicate the current number of vacancies at (insert) health service. (If vacancies exist information re level of nurse and length of time vacancy has existed would be useful).

4. What do you think are the issues that cause difficulties/problems in attracting and recruiting nurses to your area?

5. Can you recommend strategies that from your perspective would assist in recruiting the best people for nursing positions at (insert)?

Appendix 6 Workshops

Dates and locations for workshops
Ministerial Taskforce — Nursing Recruitment and Retention

Workshop	*Date*
Cairns	Tuesday 27 April 1999
Weipa	Thursday 29 April 1999
Toowoomba	Friday 7 May 1999
Mt Isa	Tuesday 11 May 1999
Townsville	Thursday 13 May 1999
Princess Alexandra Hospital	Friday 14 May 1999
Roma	Monday 17 May 1999
Gold Coast Hospital	Thursday 20 May 1999
Gladstone	Monday 24 May 1999
Redcliffe	Wednesday 26 May 1999
Longreach	Monday 31 May 1999

Formal consultation program

8:15am *Welcome and Registration*
8:30am Taskforce Background
8:45am Focus Group Activities
10:15am *Morning Tea*
10:30am Focus Group Activities
11:45am *Lunch*
12:30pm Corporate Approach to Nursing
1:30pm Best Practice Model of Recruitment
2:30pm Supply Strategies
3:30pm Summation: Where to from here?
4:00pm *Close*

Appendix 7 Focus groups process

Workload issues

1. What does the term “workload” mean?
2. What factors impact on workload — positively, negatively?
3. Outline strategies currently employed in the facility in which you work, to manage workload issues?

Rostering practices

1. What are the rostering principles, policies or protocols in place to provide guidelines for rostering in the facility in which you work?
2. Is there equity and fairness with the current system?
3. What strategies do you believe should be in place to provide guidelines for rostering?

Patient dependency

1. How does the facility in which you work measure the need for nursing staff requirements to manage patient care?
2. What form of feedback from this is provided for nursing personnel? (How is this feedback used?)
3. Is this system effective? Please provide examples.

Rewards/opportunities and performance

1. What do you consider to be a reward?
2. Do you believe rewards should be provided in nursing and if so give examples.
3. What do you consider to be an opportunity?
4. What are the barriers?
5. Outline what the term “performance management” means in relation to the nursing role?
6. Is there a performance management process in place in the facility in which you work?
7. Is the process effective? Please provide examples.

Career structure

1. Do you believe you have a sound knowledge of the elements and intent of the current career structure?
2. Do you believe the current structure has had a positive effect for nursing in Queensland Health? (Provide reasons for answer).
3. What factors impact on the career structure — positively, negatively?
4. Does the career structure meet the current health delivery structure? (Provide reasons for the answer).

Models of nursing care

1. What do you understand by the term "models of care" when applied in the nursing context?
2. Is a specific model of nursing care utilised in the facility in which you work? Please provide details and evaluate effectiveness.
3. Has the facility in which you work undertaken any work practice reviews within the previous two years? (1997-1999).
4. Do you believe there are linkages between the current model of nursing care and nursing workloads? (What works well. Is further exploration required. Provide examples).

Appendix 8 QNC interview format for DONs (or nominee)

Name and Title ______________________

Health Care Agency: ______________________

Date: __________

	Criteria	*Comments*
1.	• Number of new beginning level Registered Nurses employed each year. • Number of intakes per year.	
2.	• New beginning level Registered Nurse transition support. - *Is there a structured program for new beginning level Registered Nurses?* - *What proportion of new beginning level Registered Nurse employees undertake the program?* - *What processes are in place to support new beginning level Registered Nurses who are not undertaking the program?* • What funding is available for transition support? - *Cost per beginning level Registered Nurse.* • Content. - *Obtain a copy if possible.* • Who conducts/coordinates the support process? - *Qualifications/experience?* • Evaluation and review of process. - *How frequently is the process reviewed?* - *What parameters are used to evaluate the program and implement change?* - *Are key stakeholders involved in the review and evaluation?* - *Are continuous quality improvement mechanisms utilised in the review?* - *Does the evaluation process inform change in the process?*	
3.	• Preceptors, facilitators and/or mentors. - *Are new beginning level Registered Nurses assigned to a preceptor, facilitators and/or mentor?* - What criteria are used to select preceptors, facilitators and/*or mentors?* - *What programs/processes are in place for the preparation of preceptors, facilitators and/or mentors?* - *What programs/processes are in place for ongoing support for preceptors, facilitators and/or mentors to ensure their role effectiveness? (Please specify amount of relief time/ non contact time allocated)* - *What processes are in place to evaluate the preceptor, facilitators and/or mentor in their role?*	

Criteria	*Comments*
- *What processes are in place to provide feedback to the preceptor, facilitator and/or mentor about their proficiency in the role?* - *What acknowledgment do the employer and/or peers of the preceptors, facilitators and/or mentor's contribution make to nursing and the nursing service in the health care agency?*	
Other Comments	

Appendix 9 QNC focus group format for beginning level RNs

Interview format for beginning level Registered Nurses

Health Care Agency: ______________________________

Date: ______________

	Criteria	*Comments*
4.	• New beginning level Registered Nurse transition support. - *Is there a structured program for new beginning level Registered Nurses?* - *If there isn't a structured program what support mechanisms are in place to assist you?* • Orientation to the workplace. - *Did you participate in an orientation to the health care agency?* • Content of support process. - *Are you aware of the aims and content of the transition program?* - *Were you involved in identifying your individual learning needs?* - *Were the identified needs utilised in developing a transition support plan for you?* - *Are your needs actively managed through the identification and promotion of professional behaviours?* - *Do you believe that transition support enables you to effectively apply and consolidate the knowledge and skills learned in the pre-registration program?* - *Do you feel competent in fulfilling your role as a registered nurse? (Develop narrative regarding stories of nurses — if they feel competent then why and if not, why not.)* • Who conducts the support program/process? • Evaluation and review. - *Are you involved in the program review?*	
5.	• Evaluation and feedback to beginning level Registered Nurses. Are you involved in your assessment or evaluation?	
6.	• Preceptors, facilitators and/or mentors. *Are you assigned to a preceptor, facilitators and/or mentor?* - *Do you provide feedback to the preceptor etc about their performance?* - *Is the preceptor supported in their role?* - *Does the preceptor have adequate skills in preceptorship/practice?* - *Do they have sufficient time for preceptorship?* - *Is there a process for communication of concerns about a preceptor's etc performance?*	
Other comments		

Focus group format for preceptors, facilitators and mentors

Health Care Agency: ______________________

Date: __________

	Criteria	*Comments*
7.	• New beginning level Registered Nurse transition support. - *Is there a structured program for new beginning level Registered Nurses?* *If there isn't what else is provided for the new beginning level Registered Nurse?* - *Are all new beginning level Registered Nurses involved in the program and/or a support process.* - *Are the individual support needs of the new beginning level Registered Nurse identified?* - *Are the identified needs of the new beginning level Registered Nurse utilised in the developing a transition support program or process?* • Content of program and/or support process. - *Are you aware of the aims and content of the program and/or support process?* - *Does the transition support program and/or support process enable the new beginning level Registered Nurse to consolidate and apply the knowledge and skills learned in the pre-registration program?* - *At the completion of the program and/or support process are new beginning level Registered Nurses confident in fulfilling their role?* - *At the completion of the program and/or support* process *do new beginning level Registered Nurses consistently demonstrate competence for practice against minimum competency standards for registration?* • Who conducts the program and/or support process? - *Are you involved in the conduct of the program and/or support process?* - *What are your qualifications or experience?* • Evaluation and review of program and/or support process. - *Are you involved in the review?* - *What parameters are used to evaluate and implement change?* - *Does the evaluation process inform change?*	
8.	• Evaluation and feedback to new beginning level Registered Nurses. - *Are you involved in the assessment or evaluation of new beginning level Registered Nurses?* - *Do you provide feedback to the new beginning level Registered Nurse about their performance?* - *Is there a process for communication of concerns about a new beginning level Registered Nurse's performance?*	

Criteria		Comments
9.	• Preceptors, facilitators and/or mentors. - *Are new beginning level Registered Nurses assigned to a preceptor, facilitators and/or mentor?* - *What criteria are used to select preceptors, facilitators and/or mentors?* - *What programs/processes are in place for the preparation of preceptors, facilitators and/or mentors?* - *What programs/processes are in place for ongoing support for preceptors, facilitators and/or mentors to ensure their role effectiveness?* - *What processes are in place to evaluate the preceptor, facilitators and/or mentor in their role?* - *What processes are in place to provide feedback to the preceptor, facilitator and/or mentor about their proficiency in the role?* - *What acknowledgment the employer and/or peers of the preceptor make's, facilitators and/or mentor's contribution to nursing and the nursing service in the health care agency.*	
Other comments		

Appendix 10 RN (first year graduate) questionnaire

Q1 Please identify the type of health care institution where you are now employed.

HOSPITAL 1
COMMUNITY 2
PRIVATE SECTOR 3
OTHER *(please specify)* ______________________________ 4

____

Q2 If this is not the same as the health care institution where you first worked in 1998, please identify the type of health care institution where you first worked in 1998.

HOSPITAL 1
COMMUNITY 2
PRIVATE SECTOR 3
OTHER *(please specify)* ______________________________ 4

____

Q3 In the table below enter the type/s of units in which you worked in 1998, the length of time you spent in each unit and the total number of new graduates working in the unit at the time of your stay.

Type of unit (medical, surgical, community, mental health, midwifery, paediatric, aged care, domiciliary, small rural health institution etc).	Length of stay in unit (please use weeks — e.g. 8 weeks).	Number of other new graduates also employed in the unit at the same time. (If none please enter zero. If not known please enter N/A.)

Q4 During your first year post-registration did you participate in a formal "New Graduate Program"?

YES 1
NO 2
IF NO GO TO Q8

Q5 What components of your new graduate program were beneficial in facilitating your transition to the role of registered nurse?

____
____
____

Q6 What (if any) components of your new graduate program were not beneficial in facilitating your transition to the role of Registered Nurse?

____
____
____

Q7 If YES, what was the length of this program?

LESS THAN ONE WEEK	1
ONE TO TWO WEEKS	2
THREE TO FOUR WEEKS	3
2 - 6 MONTHS	4
7 - 12 MONTHS	5

Q8 Do you believe that you always received sufficient support for your responsibilities when you commenced in that unit?

YES	1
NO	2

IF YES GO TO Q10

Q9 If NO, what were the areas where you believe you could have been given more support?

____

____

Q10 Which key member of staff orientated/integrated you into the unit when you first commenced?

PRECEPTOR	1
CLINICAL NURSE	2
C.N.C.	3
N.P.C.	4
WARD NURSING STAFF	5
OTHER (please specify) ____________________	6

Q11 During the first twelve months as a new graduate were you preceptored at any stage by a registered nurse?

YES	1
NO	2

IF NO GO TO Q14

Q12 If YES, was a Preceptor provided for each new placement?

YES	1
NO	2

IF NO GO TO Q14

Q13 During your first twelve months as a registered nurse how satisfied were you with the preceptoring
that you received?

VERY SATISFIED	1
SATISFIED	2
DISSATISFIED	3
VERY DISSATISFIED	4

Do you have any further comments on your preceptoring?

____

____

____

Q14 On average, how long did you work in each unit before you were given the responsibility of a full client/patient load?

GIVEN FULL PATIENT LOAD FROM DAY ONE	1
1 DAY	2
2 - 3 DAYS	3
4 - 7 DAYS	4
MORE THAN ONE WEEK	5
VARIED CONSIDERABLY FROM UNIT TO UNIT	6

Q15 How long did you work before you commenced night duty?

LESS THAN 6 MONTHS	1
MORE THAN 6 MONTHS	2
DID NOT WORK NIGHT DUTY	3
(IF YOU DID NOT WORK NIGHT DUTY, GO TO Q18)	4

Q16 Do you believe that you were well prepared for the responsibility of night duty when you first commenced this shift?

YES	1
NO	2
IF YES GO TO Q18	

Q17 If NO, please comment on the areas that you believe were problematical.

____

____

Q18 How often was your performance as a registered nurse evaluated?

AT THE END OF EACH UNIT PLACEMENT	1
MONTHLY	2
EVERY 2 - 3 MONTHS	3
EVERY 4 - 6 MONTHS	4
EVERY 7 - 12 MONTHS	5
AT THE COMPLETION OF EMPLOYMENT	6
NEVER	7

Q19 Who, in evaluating your performance, was most involved? (circle all that apply)

PRECEPTOR	1
STAFF DEVELOPMENT OFFICER	2
CLINICAL NURSE	3
C.N.C.	4
N.P.C.	5
OTHER (please specify) ____________________	6

Q20 Do you believe that your university education prepared you appropriately for your role as a newly registered nurse?

YES	1
NO	2
IF YES, GO TO Q22	

Q21 If NO, what were the areas where you believe you required further preparation?

____

____

Q22 What further education or training are you presently undertaking?

____

____

Q23 Are you still paying off a HECS debt?

YES 1
NO 2
IF YES GO TO Q24
IF NO GO TO Q25

Q24 (a) If YES, does the HECS debt influence your decision to undertake further education and training?

YES 1
NO 2

(b) Please explain how the debt will influence this decision.

____

____

Q25 Please make any further comments that may identify your perceptions of your integration as a registered nurse into the workforce.

____

____

THANK YOU FOR YOUR PARTICIPATION IN THIS SURVEY.

Appendix 11 Invitation to submit

INVITATION FOR SUBMISSIONS

TO

THE MINISTERIAL TASKFORCE NURSING RECRUITMENT & RETENTION

Consultation with and involvement of nurses employed in Queensland

Submissions are invited from nurses and other interested parties (Other Health Professionals, both individuals and groups)

March 1999

All submissions to be forwarded to:

Nursing Advisory Unit
Level 6
Queensland Health
147 - 163 Charlotte Street
Brisbane Q 4000 GPO
Box 48 Brisbane Q 4001

Phone (07) 3234 0250
Fax (07) 3234 0062

All submissions will be treated confidentially

1. INTRODUCTION

The Ministerial Taskforce — Nursing Recruitment and Retention was established in October 1998 as an initiative of the current government.

The terms of reference for the Taskforce are to:

- undertake a comprehensive review of the pre and post registration education, training and staff development needs of nurses to better match workforce planning needs.
- develop guidelines for the management of nursing resources and workloads
- promote the introduction of family friendly rostering and management practices

A representative Steering Committee to guide the project has been established.

2. SCOPE

The Steering Committee for the project has established five key areas. They are:

- Undergraduate/Graduate Transition Support.
- Flexible Work Environment — includes management practices, professional development and opportunities, rewards, workloads and rostering.
- Corporate Approach for Queensland.
- Supply Strategies — the numbers of nurses and qualifications needed to meet present and future needs.
- Best Practice Models for Recruitment.

3. INVITATION TO SUBMIT

The Steering Committee for the Ministerial Taskforce seeks your views on the relevant issues, challenges and opportunities for nurses employed by Queensland Health. If you wish to raise issues to inform the direction of the Taskforce, please use the following guiding topics (as applicable for your organisation) and forward your submission to the Nursing Advisory Unit by Friday 2 May 1999. Please indicate in your submission the levels of nurses/other personnel who have contributed, the type of organisation/services provided, and its location. Submissions need only be brief.

1. **Are there any impediments to recruiting and retaining the best person for the position in your working environment?**
2. **For each of the following topics please outline barriers, potential strategies to address the issue, and opportunities for nursing in this area.**
    - **pre registration education**
    - **transition support for new graduates**
    - **management of nursing resources eg accommodation, career opportunities and incentives, structure**
    - **workloads**
    - **family friendly initiatives eg rostering, child care**
    - **post registration education**
    - **training and staff development**
    - **management practices**

Appendix 12 Discussion paper — OPs

Discussion paper
The dangers of using OP cut-offs to infer course popularity and individual ability in relation to pre-registration nursing courses in Queensland

Introduction: The problem

In Queensland, from the 1994 intake to the 1997 intake the OP cut-off for Bachelor of Nursing (pre-registration)[1] has decreased in rank in about three quarters of the institutions offering the course (in the remaining institutions the cut-off has remained comparatively stable). From 1998 to 1999 the cut-offs have slightly increased in rank or stabilised.

In certain sectors of the community there exists the incorrect notion that this observed lowering in standard of the OP cut-off means that:

1. nursing is losing popularity as a profession; and
2. as a consequence, persons of lower general ability are being accepted into nursing courses in order to fill quotas.

The purpose of this document is to dismiss this notion by asserting the following[2].

1 An OP does not measure the ability of a student to complete a nursing course

An OP is designed to measure the overall achievement of a person. It is not a measure of ability or aptitude, nor is it a predictor of future success.

2 An OP cut-off is not a good measure of any quality of a group

Put simply, an OP cut-off for a course is the OP of the last student accepted into that course[3]. As such, the OP cut-off does not measure any general quality of the group of students in that course.

3 In terms of overall achievement (as measured by the OP), the overall quality of students enrolling in a Bachelor of Nursing (pre-registration) has remained reasonably stable

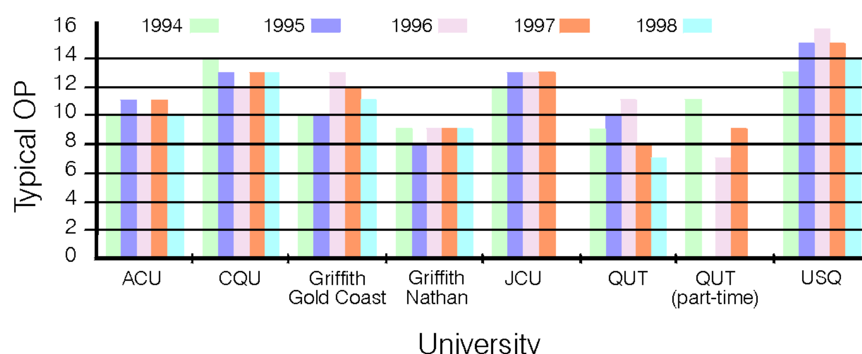
A more appropriate use of the OP is to compare the typical (median) overall achievement of cohorts of students enrolling in a Bachelor of Nursing (pre-registration). The following bar-plot shows that in most instances the typical OP has remained reasonably stable over the past five years. In other words, within most universities offering the course the overall achievement level of students enrolling in a Bachelor of Nursing (pre-registration), as a whole has not decreased.

1 For simplicity, in this paper any undergraduate tertiary course leading to registration with the Queensland Nursing Council is referred to as BN (pre-registration).

2 Please note that this document was not produced to make comment on the appropriateness of the standard of achievement of persons entering the Bachelor of Nursing (pre-registration) courses in Queensland universities.

3 Typically, a university does not pre-set the OP cut-off for a particular course, instead applicants are rank ordered based on their OP and QTAC works down the applicant list until the quota for the course is filled. The OP of the last applicant accepted (from the list) is the OP cut-off.

Figure 1 *Trend in typical OP for enrolling students Bachelor of Nursing (pre-registration) courses — Queensland*



4 An OP cut-off is not a measure of popularity of a course

For any course, it is possible for the OP cut-off to decrease in rank even though the course has not lost popularity. Consider the following two points, over the past five years:

1. The total number of persons applying for tertiary study has decreased only slightly
2. The overall number of university places has increased by more than 20 percent (see Table 1).

The net effect is that over this period applicants further down the OP list have had to be accepted by universities to ensure that quotas were filled. That is, the OP cut-offs for most courses (not just nursing) would probably have decreased in rank over this period.

Table 1 *A comparison of the number of tertiary applicants and tertiary places in Queensland*

Year	*1994*	*1995*	*1996*	*1997*	*1998*
Number of applicants	61226	58865	59906	60919	59596
Number of places	31908	34451	39451	39600	39447

5 Overall, Bachelor of Nursing (pre-registration) is not losing popularity

Perhaps a more reliable measure of popularity of the course would be the percentage of people applying for tertiary study through QTAC *who* placed Bachelor of Nursing (pre-registration) as their first preference. The table below shows that from 1994 to 1998 this percentage has remained relatively constant at just over three percent. That is, based on this measure the course is not losing popularity.

Table 2 *Percentage of applicants placing Bachelor of Nursing (pre-reg) as first preference*

Year	*1994*	*1995*	*1996*	*1997*	*1998*
Percentage	3.3	3.2	3.3	3.1	3.2

Appendix 13 Annual turnover rate

Permanent staff *Average annual turnover at district level 1994-1998*

District Name	All	Streams									Nursing Stream Sex	
		All Non-Nursing	Med	Dental	Nursing	Admin	Prof	Tech	Op	Trade	Female	Male
Corporate Office	23.8	23.8				23.3	19.9	23.9	28.5			
Banana	23.4	24.8			22.2				14.3		22.2	
Bayside	15.8	16.7			14.6	17.2	18.8		15.2		14.3	
Bowen	19.9	17.8			22.1				14.7		22.1	
Bundaberg	16.8	17.4	46.1		16.0	13.4	26.9		11.7		16.0	
Cairns	20.5	21.9	38.7		19.2	20.8	23.0	17.2	16.8		18.8	26.2
Cape York	43.1	42.9							45.3			
Central Highlands	30.6	31.3			30.1						29.5	
Central West	54.3	50.7			58.6	53.8			42.2		57.6	
Charleville	25.0	20.5			31.1				15.1		29.4	
Charters Towers	16.6	16.7			16.0				12.8		18.2	11.5
Gladstone	26.0	28.4			23.7				27.0		23.6	
Gold Coast	19.0	21.2	41.1		16.5	14.8	18.0	18.0	14.9		16.3	17.9
Gympie	13.3	14.8			12.1				10.4		12.0	
Fraser Coast	16.4	16.3	48.9		16.4	11.4	17.7		9.6		15.9	24.1
Innisfail	29.5	30.9			28.0				26.6		27.2	
Logan-Beaudesert	22.5	25.8	44.7		19.8	17.9	31.8	20.8	15.9		19.7	20.8
Mackay	23.3	25.4	49.6		21.0	21.0	27.3		18.2		20.5	55.8
Moranbah	24.4	26.5			22.3				20.0		22.4	
Mt Isa	36.2	32.8			39.4	37.7			26.1		38.0	
North Burnett	25.4	22.4			28.5				20.2		27.8	
Northern Downs	19.6	18.6			20.8				16.0		20.1	
Redcliffe-Caboolture	16.8	19.1	46.8		14.5	11.0	17.9		10.8		14.2	20.8
Rockhampton	19.8	17.7	26.9		21.8	20.5	26.9	19.4	12.2		21.3	24.6
Roma	24.4	25.0			23.4	40.5			13.9		22.3	
South Burnett	16.6	16.9			16.3	17.9			12.4		16.3	
Southern Downs	17.4	17.9			16.7	37.3			12.5		16.9	
Sunshine Coast	16.6	18.3	40.3		14.0	15.6	16.2	11.6	12.6		14.4	11.0
Tablelands	13.8	13.1			14.4				10.8		14.2	
Prince Charles	16.8	17.4	28.5		16.0	19.3	23.8	17.5	12.5	12.3	15.9	17.2
QE II	21.9	23.3	36.9	18.4	18.4	27.9	24.8	26.9	15.6		17.6	
Toowoomba	21.4	21.4	38.8		21.2	21.9	22.1	23.6	15.8	20.0	23.2	14.4
Torres	29.2	25.3			37.0				21.0		38.8	
Townsville	23.3	22.9	43.5		23.8	16.9	28.6		15.7	25.1	23.7	24.3
West Moreton	14.9	15.9	26.2		13.7	15.2	20.1	15.6	12.3	12.1	14.9	11.0
Mater	19.5	19.9	43.5		18.8	13.8	15.1	14.5	11.7	4.3	18.9	17.3
Princess Alexandra	18.9	14.4	15.9		24.2	16.6	15.0	11.0	13.4	8.7	24.4	22.8
Royal Children's	23.4	24.7	30.3		22.4	28.1	25.8		16.7		22.2	26.0
Royal Brisbane	21.1	19.5	32.1	34.2	23.9	18.1	18.1	13.6	16.1	13.8	23.8	25.1
Royal Women's	18.7	19.3	31.3		18.3	16.4	29.8		13.2		18.1	
All Districts	20.1	20.0	36.2	33.1	20.2	19.3	21.7	18.0	14.9	12.4	20.4	20.0

Appendix 14 Mental health report

Report from the Mental Health Nursing Expert Working Group, July 1999

The Mental Health Nursing Expert Working Group coordinates its activities with the Ministerial Taskforce — Nursing Recruitment and Retention

Purpose

To advise Mental Health Unit on the specific issues and strategies that need to be progressed to ensure that the mental health nursing workforce is capable of meeting the current and emerging health service needs in Queensland.

To seek support for the recommendations of the Mental Health Nursing Expert Working Group within the context of the *Framework for the Development of the Future Mental Health Workforce in Queensland* (1999) project.

Background

The Ministerial Taskforce — Nursing Recruitment and Retention was established to review workforce issues and the recruitment and retention of nurses in Queensland. The Steering Committee for the Taskforce determined that it would manage the project through the establishment of five expert working groups each with a specific topic to address. These were Undergraduate and Transition Support, Recruitment, Supply of Nurses, Flexible Work Environment, and the Corporate Approach to Nursing. Given the move towards an integrated approach to patient care and rapidly changing structures within mental health services, a Mental Health Nursing Expert Working Group was established. The Steering Committee agreed that the Mental Health Nursing Expert Working Group would coordinate its activities with the Ministerial Taskforce — Nursing Recruitment and Retention (Figure One) in order to reduce duplication and provide a vehicle for the progression of specific issues affecting nursing in this area.

The Mental Health Nursing Expert Working Group is comprised of representatives from District Mental Health Services, the University sector and the Australian and New Zealand College of Mental Health Nurses. Representation on this group was critical to ensure equity and that the issues were relevant to all areas. The group included key stakeholders from metropolitan, regional and rural areas. The issues raised in this document have been forwarded to the Ministerial Taskforce — Nursing Recruitment and Retention for inclusion in their report and recommendations to the Minister.

Outcomes of the Mental Health Nursing Expert Working Group

The issues are conceptualised from a strategic view of mental health nursing and have been identified as short and long term strategies. It was the opinion of the expert working group that the long term strategies require a concentrated period of attention to ensure that the mental health nursing workforce is able to meet the requirements of Queensland Health Mental Health Services in the coming decade. These issues have become increasingly urgent as new mental health services are developed and decentralised across the State and the number of nurses undertaking mental health endorsement courses continue to decline. The *Framework for the Development of the Future Mental Health Workforce in Queensland* (1999) supports these concerns in the articulation of the framework's objective to enhance workforce capability in nursing from a current growth of 3.1per cent to five per cent by 2006. This projected growth also includes an expected increase in the proportion of registered nurses and endorsed mental health nurses in the clinical services.

One of the key strategies of the framework is *Workforce Capability,* which focuses on promotion, coordination and development of new mental health nurses. This strategy concentrates on the undergraduate or recent graduate and steers them toward the mental health pathway through positive exposure in undergraduate clinical placements, graduate programs, attractive professional development and career path opportunities. An equally important barrier highlighted in the discussions of the Mental Health Expert Working Group is the requirement for postgraduate university qualifications that lead to endorsement. This requirement is costly, time consuming and provides little incentive for the individual. This is further complicated since endorsement is no longer a mandatory registration requirement for employment in mental health settings (Nursing Act 1992). As a result Queensland Health cannot request mental health nursing endorsement as a qualification requirement.

The strategies for the purpose of this discussion have been identified as short and long term. This separation should be considered as time based only and any further work should be conceptualised in a strategic framework that focuses on improving the capability of the mental health nursing workforce. As nursing currently represents 72 per cent of the clinical workforce in mental health services these issues need urgent progression.

Whilst it is acknowledged that the Mental Health Unit is strongly committed to a mental health workforce strategy, the expert working group have identified a range of core project activities specific to mental health nursing. The expert working group believes that this work could only be achieved through the allocation of a fulltime project officer with knowledge and experience in mental health nursing. Ideally this position would be located under the strategic leadership of the recently approved workforce framework project.

The broad project framework would include the identification of key stakeholders, establishment of an expert reference group and professional networks, further investigation and data collection in the critical issues identified and the formulation of recommendations. The structure and representation of the expert reference group would ideally

be based on a zonal model consistent with the new organisational structure of Queensland Health. Representatives could be sought from the Northern, Southern and Central Zones, a University representative and an Australian and New Zealand College of Mental Health Nursing representative in addition to other key stakeholder groups. This group could then identify strategies for broader consultation through existing structures.

Additional activities may arise and require attention from the project if they assist in the development of practices likely to create a workplace that has a strategic approach to recruitment and retention, professional development and employment satisfaction of nurses in the specialty area of mental health nursing. The Mental Health Nursing Expert Working Group has identified two specific stages and strategies to enhance the development of a professional, capable and flexible mental health nursing workforce. Further stages may be identified as the project progresses but could be included in the broader mental health workforce framework project.

Phase one — short term strategies

Financial issues have been identified by students and the workforce as a major deterrent in seeking entry to Graduate Diploma and Masters of Mental Health Nursing programs. Each of these courses leads to mental health nursing endorsement from the Queensland Nursing Council. The Council reports that endorsements continue to decline. The expert working group believe that this problem is multifaceted and includes financial barriers, lack of flexibility in course delivery, equity and access to these courses and lack of supportive infrastructure in the clinical services leading to lower than desired recruitment and retention rates. These factors directly impede Queensland Health's ability to reach the already established target of 100 new mental health nursing endorsements every year to meet the current and emerging clinical service needs. The following strategies have been agreed to by the expert working group to address the current shortage of endorsed mental health nurses in the workforce.

Scholarships

- Establish a process for the selection and allocation of mental health nursing scholarships in Queensland that ensures equity and access. The group strongly supported the proposed division of one third of the cost to the student with the remaining two-thirds being funded by Queensland Health.
- Provide flexibility in the allocation of scholarships to avoid depleting the student numbers currently undertaking postgraduate studies in mental health. It is recommended that the group of current postgraduate students employed by Queensland Health be provided with partial scholarships for the duration of their studies. This option would address the possible resignation from current courses and employment with re-entry then sought under the scholarship scheme.

- Extend the initial nursing scholarship scheme (1999-2000) to a recurrent budget based on current workforce needs for the next five years and evaluate in context of the outcomes of *The Framework for the Development of the Future Mental Health Workforce in Queensland* (1999).

Workforce support

- Investigate the Districts current practices, models and ability to support both new graduates and post graduate mental health nursing students in the workforce and make recommendations on a best practice framework for adoption in Queensland Mental Health Services.
- Develop a consistent approach to preceptorship and Graduate Certificate programs into mental health services that reflects the principles of University-Industry partnerships, equity and access.

Marketing

- Promote mental health nursing through a clearly developed marketing strategy that incorporates the Scholarship Scheme to attract new graduates into the specialty practice of mental health nursing.

Phase two — long term strategies

The expert working group have previously reviewed and provided feedback on *The Framework for the Development of the Future Mental Health Workforce in Queensland* (1999). The group strongly supported the achievement of two project officers within Mental Health Unit to progress the strategies raised within this document. The following issues have been raised in our discussions for attention within the broader framework project. As mental health nurses comprise a major part of the mental health workforce (72 per cent) it is imperative that this group receive initial priority within the current project. The long-term strategies for this project are categorised under the broad areas of workplace support, educational and organisational issues.

Workplace support

- Review current practices and frameworks for clinical placements of undergraduate students in mental health services and make recommendations on for a best practice model for Queensland which includes financial and infrastructure implications
- Review current practices and frameworks for mentoring and preceptoring new or less experienced staff and make recommendations for a best practice model for Queensland which includes financial and infrastructure implications
- Review current practices and frameworks for the practice of clinical

supervision of existing and experienced Registered Nurses in mental health services and make recommendations for a best practice model for Queensland which includes financial and infrastructure implications

- Examine the effect environmental stresses in the workplace have on undergraduate nurses in relation to entering the mental health field (with an emphasis on risk assessment and risk management)
- Examine the effect environmental stresses in the workplace have on retention of experienced clinicians within the mental health services and their sub-specialties (with an emphasis on risk assessment and risk management)

Educational issues

- Examine and make recommendations on the current level and content of mental health subjects in undergraduate nursing courses
- Examine the nature and extent of undergraduate exposure to mental health nursing including length, suitability and flexibility of clinical placements. The group would suggest that extended and well supported placements by experienced clinical facilitators during undergraduate placements would assist with recruitment into this specialty
- Examine the availability, flexibility, cost restrictions, and level of graduate satisfaction with current post graduate nursing programs within Queensland
- Examine the need for and content of a refresher program in mental health nursing to encourage non-practicing mental health nurses to return to employment
- Review current approaches to professional development and ongoing clinical education to maintain a contemporary and capable mental health nursing workforce
- Review existing programs (National and international) and make recommendations to develop specific qualifications in the emerging sub-specialty areas of mental health

Organisational issues

- Review and make recommendations regarding an appropriate skill mix requirements (endorsed, non-endorsed and enrolled) of the nursing component of mental health workforce in mental health settings (inpatient, community and subspecialty areas) in Queensland
- Facilitate the development of a culture of problem solving and ongoing learning within mental health settings through an articulated framework of professional and leadership development in all District Mental Health Services with appropriate infrastructure and resources
- Collaborate with the tertiary sector to develop mental health nursing partnerships and joint appointments with the health system at the clinical, educational and research interfaces

- Review and make recommendations on the current allocation of nurse educator resources across the Districts (particularly in regional and remote areas) to ensure a consistent amount of mental health education resources per nursing FTE is allocated in each workplace
- Review and make recommendations on the number of nurse educators and/or clinical facilitators to support educational programs and continuing professional development for mental health nursing
- These three broad areas of activity reflect, support and expand upon the issues identified in the Mental Health Unit document: *Framework for the Development of the Future Mental Health Workforce in Queensland (1999)*. A specific project plan encompassing these specific nursing issues should be seen as a priority within this project framework.

CONSULTATION

Consultation on these issues has occurred to ensure the core issues reflect the concerns of all relevant parties. These processes included:

- Establishment of the Mental Health Nursing Expert Working Group as a formal component of the Ministerial Taskforce — Nursing Recruitment and Retention to recognise the specific issues affecting mental health nursing
- Formal submissions and feedback through this workgroup on the discussion document *The Framework for the Development of the Future Mental Health Workforce in Queensland (1999)* prepared by Mental Health Unit.
- Broad representation on the Mental Health Nursing Expert Working Group comprising of District Mental Health Services (metropolitan and regional), the University sector and the Australian and New Zealand College of Mental Health Nurses.

RECOMMENDATIONS

That the Mental Health Unit approve the:

1. Establishment of a project officer for a period of not less than six months to progress the specific nursing issues and strategies raised by the Mental Health Nursing Expert Working Group
2. Recruitment to the project position be an experienced mental health nurse with suitable project experience
3. Position be linked to existing infrastructure within the broader mental health workforce framework project.

Appendix 15 QNC position statement

Queensland Nursing Council position statement on transition support processes for beginning level nurses

1.0 Introduction:

1.1 The purpose of this position statement is to provide guidance for the review and implementation of transition support processes for beginning level nurses.

2.0 Background:

2.1 Transition support for beginning level nurses is an integral part of workforce planning. The absence of appropriate support for beginning level nurses within the work environment can result in a high level of job dissatisfaction and attrition for both new graduates and the more experienced nurses who are expected to provide guidance and support during the transition from student to practitioner. In order to minimise the impact of dissatisfaction on the workforce, it is necessary to provide support for both groups.

2.2 Registration, enrolment or authorisation to practise midwifery or psychiatric nursing is dependent on the nurse demonstrating that minimum competencies have been achieved. Educational preparation is directed towards this end. Transition support is directed towards enabling the beginning level practitioner to effectively apply the knowledge and skills learned in their course.

3.0 Definitions:

3.1 *Beginning level nurses* are new graduates from courses leading to registration, enrolment or authorisation to practise midwifery or psychiatric nursing who are commencing work in their first position.

3.2 *Mentorship* is an intense relationship calling for a high degree of involvement between a novice in a discipline and a person who is knowledgeable and wise in that area (May, Meleis and Winstead-Fry, 1982:22)

3.3 *Preceptorship* is the facilitation of the integration of newly employed staff in their role responsibilities in the work setting (Alspach, 1988) by a peer with clinical expertise and a commitment to staff development who serves as a role model, resource person and teacher for a limited period.

4.0 Standards:

4.1 The expectation of the public, the nursing profession and the graduates is that new graduates will be competent beginning level practitioners. This can be facilitated by the provision of a supportive environment that enables the application of acquired knowledge and skills in the work setting. This support may involve induction, socialisation, and work skill development and may be

provided through a variety of modes such as mentorship, preceptorship or structured programs. The choice of content, length and delivery methods of planned transition support should be governed by the needs of the organisation and the graduate.

4.2 Universities, health care organisations and professional bodies have a collective obligation to undertake research and evaluation that will enhance the implementation of realistic and cost effective educational preparation of graduates and transition support programs. Such research should include identifying:

- the needs of employers in terms of the skill and ability of the new graduate necessary for effective client service;
- appropriate standards for graduates; and
- appropriate models and strategies for transition support.

4.3 The selection and recruitment of students into courses influences the level of graduate output and is therefore an important aspect of labour force planning. Participants from the education and health sectors therefore need to be aware of changes in health and educational service delivery that will influence the level of graduate need and output, and to jointly develop strategies to cope with the impact of these changes on the workforce.

4.4 Education for a professional career is a continuing process, one requiring the cooperation of all parties at all stages. Transition support for beginning level practitioners is best achieved by a collaborative endeavour between the educational and health institutions, the profession at large, and the graduates themselves. Preparation for the transition from student to practitioner should begin at the commencement of the course leading to registration, enrolment or authorisation and continue throughout that program of study and into the professional career. Consequently, close consultation is necessary amongst all concerned to ensure appropriate preparation for both the new graduate and potential preceptors and mentors.

4.5 The aim of comprehensive pre-registration programs is to prepare graduates to work in a variety of settings. Hence, support processes instituted to smooth the transition from study to work should be offered by a variety of practice settings. This approach will assist in enhancing the employment prospects of the new practitioner in potential clinical practice settings.

4.6 The transition process for beginning level nurses is complex and requires the involvement of the graduate, the employer, the experienced nurse and the educational institution. The responsibilities of the following are:

- *the graduate* — to recognise their level of competence and to seek assistance when needed
- *the employer* — to provide a supportive environment for the graduate and for the experienced nurses who are contributing their time and knowledge to facilitate the transition
- *the experienced nurse* — to guide and support the beginner
- *the educational institution* — to provide the comprehensive basis of knowledge and skill with which the graduate can commence practice and engage in ongoing professional development.

4.7 Equity is an important consideration in all aspects of this process.

All beginning level practitioners are entitled to appropriate support and such support should not be dependent on obtaining a position in a structured new graduate program. Alternative approaches such as mentorship, preceptorship and generally supportive environments are also valid means of providing transition support.

4.8 Experienced nurses who commit time and knowledge to the support of the beginning level practitioners should be acknowledged and rewarded for this contribution to the profession.

4.9 The public, the profession, the new graduate, the health agency and the educational institution, all benefit from the provision of appropriate support to beginning practitioners. All parties should therefore contribute, and decisions regarding, among other matters, funding for such processes, should be made in consultation between all parties.

REFERENCE

Alspach, J (1988) "From staff nurse to preceptor — a preceptor training program." Preceptor Handbook and Instructor's Manual, Hospitals Publications Inc NJ.

May, K Meleis, A and Winstead-Fry, P (1982) "Mentorship and scholarliness: opportunities and dilemmas." Nursing Outlook (30): 22-28.

Appendix 16 Aged care issues paper

Aged Care Expert Working Group Issues Paper, January 1999

The Aged Care Expert Working Group (chaired by Ms Sue Norrie, Principal Nursing Advisor) has developed this issues paper to identify emergent issues. This is done in the context of an ageing population together with the continuum of care approach required to effectively manage the health of older people. The Aged Care Expert Working Group will coordinate its activities with the Ministerial Taskforce —Nursing Recruitment and Retention in order to reduce duplication.

Issues

1. Workforce planning

Traditionally discussion on the 'aged care' nursing workforce has focused on the residential aged care sector. In line with population trends there is an increased percentage of clients in all settings who are 'aged care'. With the move to continuum of care models of service delivery 'aged care' nursing considerations should extend to acute and community care. Continuum of care incorporates the concepts of transitional care and integrated care.

The following issues need to be addressed:

- The age profile of nurses working in residential aged care
- The education profile of nurses working in residential aged care
- "Denial" by nurses of the increased number of clients who are older
- The turnover rate for nurses in residential aged care is low. Potentially a disincentive for individual nurses to pursue professional development
- Information required on aged care population and QH client numbers per geographical area
- Issues with unregulated health care providers
- Indigenous nurses in aged care. Mt Isa Rural and Remote Health Centre is an avenue to pursue this issue. Indigenous students a priority in EN TAFE course — link to Queensland Health Indigenous workforce strategies.

A survey conducted by Workforce Planning and Analysis in conjunction with the Ministerial Taskforce may provide relevant data about some of these issues.

2. Education

There is a need to link nursing practice and education with continuum of care concept and expose nurses, especially undergraduates and new graduates, to caring for the individual across settings/facilities.

- Need to breakdown barriers which restrict continuum of care — adjust education structure accordingly
- Clinical placements of undergraduate students in aged care settings often occurs in the first year but there would be more benefit for future recruitment if this was offered in third year
- The first year of university programs focus on health of whole person — explore potential to tap into healthy older persons e.g. retirement villages
- The lack of awareness by undergraduate students of aged care nursing as a career option (an option of aged care nursing as an elective in third year may prove beneficial for the profession in terms of future recruitment)
- Examine structure of graduate nurse transition to work programs to include acute, community and aged care placement of individual graduates. Refer to Nursing Unit Advisory Committee graduate nurse projects in this area
- Skill level of AINs / PCAs in residential aged care facilities — should training of this group be considered as an issue?
- Strategies required to encourage more aged care nurses to pursue relevant professional development
- Aged care nursing competencies are being developed by relevant professional groups.

3. Organisation

- Roles and responsibilities addressed in the Scope of Nursing Practice. However, nurses in residential settings are concerned with carrying responsibility for unregulated care providers particularly when nurses often have no input to decisions relating to skill mix and staffing numbers
- Commonwealth policy / funding model
  - No cut in Commonwealth funding but change in monitoring system. Monitoring program is based on residential classification linked to staff skill mix and related decisions are being made by owners/providers. Potentially has negative impact on staff skill mix in facilities
  - From the 1999 financial year the community package will enable 10 per cent to be directed to ‘high care’, that is, care requiring specialist procedures and access to a nurse
- Lack of career pathway for aged care nurses
- Aged care nursing not viewed by the profession/industry as a viable focus of practice either permanently or in transition
- Lack of support structure for nurses caring for aged clients
- Resources not increased to match increase in workloads
- Queensland Health is in process of planning future direction for community health services — outcomes will impact on aged care. Several nursing representatives are on this planning group
- Examine mechanisms to enhance awareness of, and competencies relating to, aged care nursing skills and knowledge. For example, effective

exchange programs between acute and/or community and aged care facilities.

4. Recruitment

- Poor image of aged care within the nursing workforce — not generally considered a viable specialist option
- Involve tertiary sector in marketing aged care
- Marketing aged care nursing/gender issues
- A positive marketing strategy to target registered nurses to specialise in aged care and for school students to consider this as a long term professional pathway is greatly needed
- Difficult to recruit nurses in rural and remote — large number of aged clients. Link to recruitment section of Ministerial Taskforce.