CDNM COUNCIL OF DEANS OF NURSING & MIDWIFERY
AUSTRALIA & NEW ZEALAND

A Submission to the National Health and Hospitals Reform Commission From the Council of Deans of Nursing and Midwifery (Australia and New Zealand) (CDNM) – 30 May 2008

The Terms of Reference for this Commission's inquiry state that *the Commission will report on a long-term health reform plan to provide sustainable improvements in the performance of the health system addressing a range of needs*. This submission addresses Item 8 in the Terms of Reference: "provide a well qualified and sustainable health workforce into the future." CDNM has had a longstanding interest in the national supply and demand for registered nurses and midwives. In 2006, it funded and published an extensive study by Barbara Preston, entitled *Nurse Workforce Futures,*[1] which examined the future supply and demand to 2010. This submission draws on that study as well as other material.

Preston projects a reduction in the shortfall of registered nurses to 470 nationally in 2010, but only if there is no improvement in staffing levels. If the national staffing level was increased to that of the current best-performing state, the 2010 shortfall would be around 7,900 – more than double the 2006 national shortfall. CDNM would argue that there is no excuse for aiming at anything less than the current best level; Australia would not do this in any other significant field of activity.

The shortfall can be overcome and a sustainable nursing workforce established by a combination of measures. The obvious two are firstly, increases in the number of those graduating from our university courses, and secondly, reduction in those leaving the profession. These measures are not as simple as they sound.

Nursing is a practice-based profession, and student nurses are required to experience substantial periods of clinical work in hospitals or equivalent facilities before they can graduate or be registered. This clinical practice is usually organised jointly by a university and a hospital. It places strains on both – extra tasks for staff in both institutions, demands for space and access to equipment and patients, and careful supervision for the safety of both patients and students. These blocks of clinical practice are becoming more difficult to organise as the numbers of students rise. Some hospitals are beginning to demand funding for their cooperation, which is beyond what universities can provide. Universities are to some degree in competition with each other to gain access to clinical places, and see with concern some new providers, not established universities, seeking to offer an accredited nursing degree program. The nursing workforce needs to grow, and the Commonwealth Government has announced its intention to increase the supply, which CDNM would applaud. However, there must be sufficient clinical places available for the proper education of all future nurses.

It is not only a matter of recruiting new entrants to the profession. There must also be measures to support new graduates when they enter the workforce. Lack of such support is a major factor in the departure of nurses, especially new graduates, from the profession, and as Preston quotes: "Of all the flows in a manpower system, wastage is

[1] B Preston, Nurse Workforce Futures, 2006

the most fundamental for manpower planning (Batholomew and Forbes, 1979, p.12)[2]". To take an instance from one state, a key point Duffield's[3] data allows us to make is that NSW Medical/Surgical wards are being staffed by new graduates and RNs with eight or more years of experience. There is thus a vacuum in the middle which we need to fix by fixing the leaky bucket rather than (merely) turning the tap on harder. Indeed, turning the tap on harder means that there is even more pressure on the more experienced RNs to support these new graduates. We need to have systems in place to provide support for the new graduates (and anyone else coming into the nursing workforce) at a more institution-based level, rather than leaving the role to individual RNs. This would be facilitated even more with models of care-delivery that facilitate a team-approach, rather than patient allocation. Another point flows on from this: where Clinical Nurse Educators were in place, Duffield et al found that staff were more likely to stay and that there were fewer 'untoward incidents'. However, clinical nurse educators are not always in place and where they did exist, they were often required to take a patient care load, rather than support its delivery by others.

There is no quick fix. An inquiry into the situation should look at:

1. The value, for patient welfare, of registered nurses compared to less-qualified staff
2. Obstacles to recruitment and advancement to graduation – especially the shortage of places for clinical practice
3. Conditions of work for new graduates, especially instances of bullying, and excessive responsibility on the new graduate
4. Support systems for new graduates.

After such an inquiry, the NHHRC should be in a position to achieve "a well qualified and sustainable health workforce into the future".

References:

Duffield et al. 2007, *Glueing it Together: Nurses, Their Work Environment and Patient Safety*, NSW Health, retrieved 30 May 2008, http://www.health.nsw.gov.au/pubs/2007/nwr_report.html

Preston, B. 2006 *Nurse Workforce Futures: Development and application of a model of demand for and supply of graduates of Australian and New Zealand pre-registration nursing and midwifery courses to 2010*, Council of Deans of Nursing and Midwifery, retrieved 30 May 2008, http://www.cdnm.edu.au/publications.html

[2] ibid. p.93
[3] Duffield et al. Glueing it Together: Nurses, Their Work Environment and Patient Safety, 2007