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Submission to the Health Workforce Study
Productivity Commission
July 2005

This submission addresses some of the issues raised in the Issues Paper and where appropriate provides a brief summary of some of the current research that may guide future directions. The paper is submitted by Professor Christine Duffield, Director of the Centre for Health Services Management at the University of Technology, Sydney.

Issues associated with nursing retention

- In a five country pilot study in which Australia participated the cost of replacing a registered nurse (RN) was $42,000 (O'Brien-Pallas, Duffield and Hayes, *in press*). A large component of the costs is lost productivity for new employees and decreased productivity for temporary staff who replace them. Costs in terms of burnout for permanent staff required to pick up an additional workload were not estimated. This is likely to be similar in most of the health professions. Greater attention to workload issues might positively impact on retention and this will become increasingly important as the workforce ages. In nursing the needs of older workers need to be considered, given the rise in acuity and shortened lengths of stay. In particular, adjustments to workload for experience and expertise may be required given the physical demands of nursing. A 'loading' for experience or undertaking additional duties of mentoring/preceptoring staff could be considered.
- Three month temporary work visas may assist with a short term staffing problem, but will also result in in productivity losses similar to those described above. Longer periods for temporary work visas should be considered.
- Common training across all health disciplines should be encouraged and supported in relation to core competencies for health disciplines. However, the concept of a generic health worker is not supported as the issues relating to recruitment and retention would not alter for a new grade of health worker.

Alternative models of care

- Rural/remote areas having difficulty recruiting medical practitioners, particularly general practitioners (GPs) (often a sole practitioner and hence on duty 24 hours per day, seven day per week) and so should be encouraged to hire nurse practitioners. An example exists in Newfoundland where no medical services were provided on the West Coast of the province following the collapse of the fishing industry and migration of many residents to the East Coast. After September 11 an influx of tourists from the USA with demands for health services led to the introduction of nurse practitioners

(NPs) who are providing a valued service despite initial reluctance on the part of the local community. The costs associated with hiring a NP vs a GP means that more than one can be hired for the same costs thus ensuring appropriate rosters and workload, and cover for annual and sick leave.

- Hospital/community models of practice should be considered where staff can work across both sectors and follow their patients to see the results of their care which is impossible now with such short lengths of staff. This could be quite motivational for nursing and allied health staff as they may have more time to develop a therapeutic relationship with patients/clients than they are able to do now.

Management Issues

- Nursing unit managers are critical for staff retention and patient safety but evidence suggests the mode for tenure in these positions is one year (Duffield et al. 2001). Increasingly with downsizing of organisations these roles have become more administrative as they have had to 'pick up' many of the middle management tasks. As a consequence they are able to provide less leadership in clinical management. Additionally increased rates of part-time staff mean that they are frequently responsible for managing far more than the full-time equivalent (FTE) establishment they might once have been (for example an establishment of 30 FTE might translate to up to 50 staff by headcount). This increases the difficulties of providing support and managing staff performance. Increased responsibilities for entering staffing data for payroll purposes further decreases the time they can spend with clinical staff. In addition, in many facilities now there is a trend to have a nurse manager over several wards rather than one, further decreasing the provision of clinical leadership which has been shown to have a significant impact on staff retention.
- Silos now exist in terms of clinical streams across facilities which, while multidisciplinary (at times), are nevertheless still silos. In addition a consequence of this trend in terms of organisational structure is that there is less focus on managing at the institutional level. The recent Institute of Medicine of the National Academies (2004) report indicates that without strong and effective nursing leadership (in the form of a nurse executive charged with decision-making responsibility for nursing staff) at the institutional level staff satisfaction and patient outcomes are adversely affected.
- Two of the most significant aspects of nursing retention are the ability to have control and influence over health outcomes and being valued for the work they do (Chiarella, 2002). Now in many clinical areas critical paths are in place. Once a patient has achieved the necessary outcomes it makes little sense for them not to be discharged by the nurse responsible for their care. Frequently they wait several hours just to be told their medical practitioner that they can go home and this gives little opportunity for effective discharge planning. This will be more important as the population ages and more frequently now returns to home alone.
- With cost-cutting measures it is not uncommon to find health professionals undertaking a variety of activities which are a waste of their skills and knowledge. Nurses often now pick up the Schedule 8 (morphine etc) drugs from pharmacy when a security guard would be a cheaper and better alternative; after hours telephone calls to the ward are answered by whomever is closest, be it a doctor or nurse or allied health staff. There are very few ward clerks employed after 4pm. Given much of the surgical activity and admissions are after-hours this adds to the burden of non-clinical activity. The Institute of Medicine of National Academies (2004) indicated in the US that 34.3% of nurses performed housekeeping duties, 42.5% delivered and retrieved food trays and 45.7% transported patients.
- Financial constraints have also led to less equipment being available. It is not infrequent now to find for example, that rather than have a glucometer at each end of a ward for diabetic patients there is only one for the ward and medical and nursing

staff waste time not only looking for the equipment but also, waiting in a queue to use it.

- While there is little Australian information, overseas there are indications that with increases in compliance measures there is an increased level of documentation. It is estimated that every hour emergency department nurses were involved in direct care, an equal amount of time was spent on paperwork (Kovner & Harrington, 2002).

Workforce Planning Information

- A minimum data set (NMDS) should be instituted which collects meaningful and similar information for all health disciplines for workforce planning purposes. The Canadian and NZ systems enable this to occur.
- Comments about nursing graduates now being able to 'hit the ground running' must be considered in the context of the skillmix and staffing arrangements on the unit. All too frequently first year registered nurses find themselves in charge of a unit within their first two to three weeks of graduation despite the fact this is not supposed to occur. This happens when the rest of the staff comprise enrolled nurses, casual staff and unlicensed staff such as assistants in nursing and personal care assistants. Accordingly they are responsible for providing not only the care that registered nurses are able to provide (e.g. medications) but also must supervise the work of other staff. Not surprisingly this is stressful and retention of these staff is difficult. Further work is needed to determine precisely what the long-term effect is on retention. This is exacerbated when new junior medical officers commence on units as well as the fact that much of the teaching has traditionally fallen to registered nurses.

References

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