ROYAL COMMISSION INTO AGED CARE QUALITY AND SAFETY

AGED CARE WORKFORCE

SUBMISSION OF THE AUSTRALIAN NURSING AND MIDWIFERY FEDERATION

INTRODUCTION

1. This submission is provided in response to the matters the Royal Commission will inquire into at the public hearings to be held in Melbourne between Monday 14 October and Friday 18 October 2019. It addresses the matters the Royal Commission will focus on:
    a. How to enhance the aged care workforce's capacity and capability to provide high quality care and support good quality of life to care recipients; and,
    b. Make the aged care sector a more attractive and rewarding place to work.
2. It is noted that Mr Rob Bonner (Director Operations ANMF SA) and Mr Paul Gilbert (Assistant Secretary ANMF Vic Branch) have lodged Statements with the Commission in response to Notices to Give Information issued by the Commission. This submission does not repeat the material in those Statements.
3. This submission addresses the subject matter of the Melbourne Hearings 3 for staff as they enter the workforce, the conditions and challenges of working in aged care, staff retention issues and what can be done to improve these with a focus the following:
    - SIZE AND COMPOSITION OF THE AGED CARE WORKFORCE (Paras 13 -97)
        - *IMPLICATIONS OF WORKFORCE DATA*
        - *EDUCATIONAL PREPARATION AND TRAINING PATHWAYS FOR THE AGED CARE WORKFORCE*
        - *SKILLS AND PERSONAL ABILITIES OF THE AGED CARE WORKFORCE*
    - CHALLENGES IN ATTRACTING AND RETAINING AGED CARE WORKERS (Paras 98-224)
        - *WAGES AND THE INDUSTRIAL LANDSCAPE IN AGED CARE*
        - *PROBLEMS CONFRONTING AGED CARE WORKERS*
        - *PERCEPTIONS OF AGED CARE AND CULTURAL VIEWS OF ELDERLY PEOPLE*
    - EFFECTIVE RECRUITMENT AND RETENTION (Paras 225-251)

4. While the central focus of the aged care sector must be the people who access aged care services and their families, the direct care workforce is fundamental to ensuring that these people are involved in and receive safe, appropriate, quality care. The most recent figures indicate that 240,000 people work in direct care in aged care.[1]

5. As Australia's population ages and members of the 'baby boomer' generation begin to reach a time in their lives when the need to access aged care services is likely to increase, the demand for a larger aged care workforce will necessarily increase. It is estimated that nearly 1 million workers will be required to meet Australia's aged care needs by

[1] 2016 National Aged Care Workforce Census and Survey-The Aged Care Workforce, 2016 xvi

2050.[2]

6. The current aged care workforce is on average older than the overall Australian workforce and as this workforce ages and enters retirement it will be necessary to ensure that younger workers enter the industry to take their place. Notwithstanding technological innovation and changes to service delivery models, current predictions indicate that our aged care workforce will need to grow by about 2 per cent annually, or triple from its current size, for the next 30 or so years to meet projected demand.[3]

7. In order to have a viable workforce in aged care that is equipped to provide safe and quality care, both now and into the future, consideration must be given to the impediments and challenges of entering and remaining in the aged care workforce. Ensuring that a career in aged care is attractive and rewarding for workers will improve the quality and safety of care for aged care recipients by attracting and retaining people with the right attitudes, qualifications, and skills. A thriving, diverse workforce requires appropriate education and training, pathways into the workforce, career development, appropriate regulation, supportive working conditions, safe work design, and a well-funded sector that values and rewards its workforce. Our submission understandably focusses on nurses and care staff but we acknowledge the need for improvements for the wider workforce, including allied health, doctors and support staff.

8. However, *A Matter of Care* revealed that in relation to the workforce, despite being one of Australia's most rapidly growing employment areas, the aged care sector suffers from many challenges related to attracting and retaining workers: high turnover and employee movement between organisations, poor employee engagement and enablement, challenges to attracting new employees, devaluation of jobs, poor workforce planning, casualisation, career bottlenecks, and poor recruitment, induction, and staff on-boarding. Indeed, as the Report notes; the aged care workforce faces significant cultural and operational barriers to change.[4]

9. It is the Australian Nursing and Midwifery Federation's view that along with the range of actions and improvements that are urgently necessary to address the systemic issues with Australia's aged care sector, appropriate, safe, quality care for any person will not be feasibly achieved or sustained without the introduction of mandated minimum safe staffing levels. Increased funding that is transparently directed to providing care for aged care consumers, diverse skills, resources, training, and capabilities are required to care for everyone in aged care, but without the minimum numbers of the right kind of staff, that care cannot be delivered effectively or appropriately.

THE AUSTRALIAN NURSING AND MIDWIFERY FEDERATION (ANMF)

10. The ANMF is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory

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[2] A Matter of Care Australia's Aged Care Workforce Strategy, Aged Care Workforce Strategy Taskforce, June 2018, 1

[3] Mr Trevor Lovelle, Chief Executive Officer, Aged and Community Services Australia, Western Australia, Committee Hansard, 27 September 2016, p. 1.

[4] Ibid.

branches, we represent the professional, industrial, and political interests of more than 275,000 nurses, midwives, and care workers across the country.

11. Our members work in the public and private health, aged care, and disability sectors across a wide variety of urban, rural, and remote locations. We work with them to improve their ability to deliver safe and best practice care in each and every one of these settings, fulfill their professional goals, and achieve a healthy work/life balance.

12. The ANMF represents almost 40,000 nurses and care workers working in the aged care sector, across both residential and home and community care settings.[1]

SIZE AND COMPOSITION OF THE AGED CARE WORKFORCE

13. The size and composition of the direct care workforce in aged care is the key ingredient in the ability to provide a decent and dignified standard of care to our increasingly frail elderly population. Put simply, the elderly cannot receive proper care unless there is an appropriate number and mix of skilled and experienced staff, which includes registered nurses (RNs), enrolled nurses (ENs) and assistants in nursing/personal care workers (AINs/PCWs).

14. The most comprehensive data available on the size and composition of the aged care workforce is provided in the National Aged Care Workforce Census and Survey (NACWCS), commonly known as the "NILS report", commissioned by the Department of Health and published periodically since 2003. The most recent data available is the 2016 Report published in 2017.[5] This data shows a significant change in the skill mix of direct care staff over the last decade in both residential and community aged care. This is a trend which is continuing and which needs to be addressed urgently both now and as we plan for future needs to develop an aged care workforce which is equipped to meet those needs.

Current Composition of the Residential Aged Care workforce

15. Overall, total PAYG employment in residential aged care in 2016 is estimated at 235,764, an increase of approximately 50 percent since 2003. Out of this total, 153,854 are employed in direct care roles. Specifically, Nurse Practitioner (NP), Registered Nurse (RN), Enrolled Nurse (EN), Personal Care Attendant (PCA), Allied Health Professional (AHP) and Allied Health Assistant (AHA) roles.

16. While the overall number of people employed in aged care appears to have grown, since 2003, the estimated proportion of employees working in direct care roles has continued to decline from 74 percent in 2003 to 65 percent in 2016.[6] The table below shows the respective number of employees over this period:

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[5] *The Aged Care Workforce 2016, op.cit.*
[6] Ibid.,12.

Table 1: Size of the residential aged care workforce, all PAYG employees and direct care workers: 2003, 2007, 2012 and 2016 (estimated headcount)

Occupation	2003	2007	2012	2016
All PAYG employees	156,823	174,866	202,344	235,764
Direct care employees	115,660	133,314	147,086	153,854

Source: Census of residential aged care facilities (weighted estimates)

17. The occupational composition of the direct care workforce has also changed dramatically over this period. Registered nurses made up 21% of the direct care workforce in 2003 but only 14.6% in 2016. Similarly, enrolled nurses have gone from comprising 13.1% of the direct care workforce in 2003 to 10.2% in 2016. In contrast, the number of care-workers, (AINs, PCWs however titled), have increased from 67,143 in 2003 to 108,126 in 2016 comprising 71.5% (almost three quarters) of the direct care workforce. In 2003 carers made up 56.5% of the direct care workforce.[7]

18. Tables 2 and 3 and Figure 1 below show the changing size and composition of the direct care workforce in terms of headcount and full time equivalent employees:

Table 2: Direct care employees in the residential aged care workforce, by occupation: 2003, 2007, 2012 and 2016 (estimated headcount and per cent)

Occupation	2003	2007	2012	2016
Nurse Practitioner (NP)	n/a	n/a	294	386
			(0.2)	(0.3)
Registered Nurse (RN)	24,019	22,399	21,916	22,455
	(21.0)	(16.8)	(14.9)	(14.6)
Enrolled Nurse (EN)	15,604	16,293	16,915	15,697
	(13.1)	(12.2)	(11.5)	(10.2)
Personal Care Attendant (PCA)	67,143	84,746	100,312	108,126
	(58.5)	(63.6)	(68.2)	(70.3)
Allied Health Professional (AHP)*			2,648	2,210
	8,895*	9,875*	(1.8)	(1.4)
Allied Health Assistant (AHA)*	(7.4)	(7.4)	5,001	4,979
			(3.4)	(3.2)
Total number of employees (headcount) (%)	**115,660**	**133,314**	**147,086**	**153,854**
	(100)	**(100)**	**(100)**	**(100)**

Source: Census of residential aged care facilities (weighted estimates).

*In 2003 and 2007 both of these categories were combined under 'Allied Health'.

[7] Ibid.,13

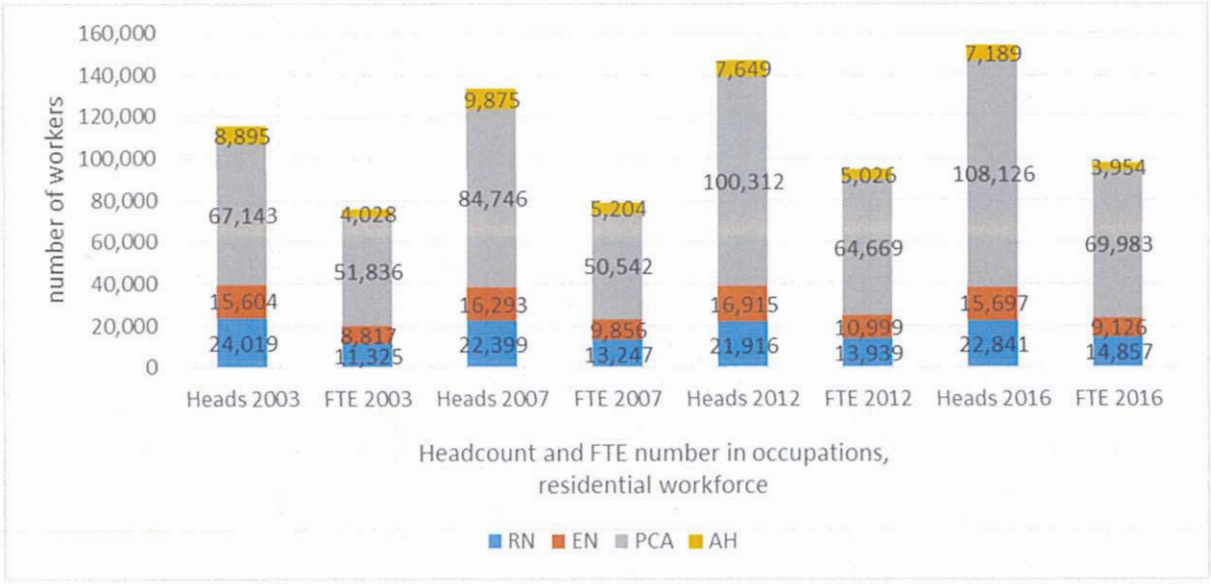
Table 3: Full-time equivalent direct care employees in the residential aged care workforce, by occupation: 2003, 2007, 2012 and 2016 (estimated FTE and per cent)

Occupation	2003	2007	2012	2016
Nurse Practitioner	n/a	n/a	190	293
			(0.2)	(0.3)
Registered Nurse	16,265	13,247	13,939	14,564
	(21.4)	(16.8)	(14.7)	(14.9)
Enrolled Nurse	10,945	9,856	10,999	9,126
	(14.4)	(12.5)	(11.6)	(9.3)
Personal Care Attendant	42,943	50,542	64,669	69,983
	(56.5)	(64.1)	(68.2)	(71.5)
Allied Health Professional*	5,776* (7.6)	5,204* (6.6)	1,612	1,092
			(1.7)	(1.1)
Allied Health Assistant*			3,414	2,862
			(3.6)	(2.9)
Total number of employees (FTE)	**76,006**	**78,849**	**94,823**	**97,920**
(%)	**(100)**	**(100)**	**(100)**	**(100)**

Source: Census of residential aged care facilities.

*In 2003 and 2007 these categories were combined under 'Allied Health'.

Figure 1: Number of the occupations for the residential direct care employees (headcount and FTE)



Note: Nurse Practitioners and Registered Nurses were combined under 'Registered Nurse' in 2016 in Figure 3.1 and Figure 3.2. Allied Health Professionals and Allied Health Assistants were combined under 'Allied Health' in 2003, 2007, 2012 and 2016 in Figure 3.1 and Figure 3.2.

19. The shift in the composition of residential aged care workforce over this period saw

the number of all direct care employees increase by 33%, while the number of registered nurses actually decreased by 6.5% in terms of numbers and 10.5% on a full time equivalent basis. Over the same period the number of residential places increased by 30% and the dependency/acuity levels of residents increased from 64% assessed as "high care" in 2003 to 89% in 2015.

20. The 2008 NILS Report *Who Cares for Older Australians?*[8] highlighted the shift noting a significant restructuring of nursing staff in nursing homes with an overall increase in nursing care delivered by staff other than registered and enrolled nurses. The Report states:

> *"Overall, these figures suggest a significant reorganisation of care in residential aged care homes so that more care is provided by PCs and less by nurses. Moreover, a greater proportion of new hires continue to be PCs suggesting that the trend towards increased use of PCs will continue"*[9].

21. This trend was confirmed in the 2012 Report and noted again in 2016:

> *"...residential facilities continue to rely increasingly on PCAs to provide direct care to residents. There has been some increase in the number of RNs, but there has been a corresponding and larger fall in the number of ENs. PCAs are the only residential direct care occupational category to substantively raise its share of employment since 2012..."*[10]

22. The steady decline in the percentage of nurses in the residential aged care workforce is of great concern. Older Australians, particularly those receiving residential aged care services, are characterised by increasing and significant care needs, multiple diagnoses, comorbidities and polypharmacy. It has been estimated that on average they have 3.4 to 4.5 separate diagnoses, 6 comorbidities, and are taking 8.1 medications.[11] Research also points to a rising trend of avoidable and premature deaths in Australian aged care facilities.[12]

23. In responding to these care needs, the aged care sector must have the capability and capacity to deal with the often complex care required around core clinical activities such as wound care, medication management and pain management. This means it is essential that the aged care workforce has the appropriate number of skilled staff, including RNs and ENs and care workers. The trend of reducing numbers of RNs and ENs in the aged care workforce must be reversed. This does not mean that care-workers should be replaced by nurses, rather that the entire workforce needs to grow. As one member told us in the 2019 ANMF National Aged Care Survey:

> *"The main problem we have is that we very rarely have the minimum staffing levels as required by government standards. They replace RNs with ENs and replace ENs with PCWs. The skill set is not there and residents suffer. There are very few casual workers available to fill sick leave. If we are one down one nurse*

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[8] Martin B. and King D., 2008 *Who Cares for Older Australians?* National Institute of Labour Studies, Flinders University, Adelaide, Australia

[9] Ibid, *10*

[10] Ibid, *12*

[11] Willis E, Price K, Bonner R, et al. 2016.Meeting residents' care needs: A study of the requirement for nursing and personal care staff. Australian Nursing and Midwifery Federation.

[12] Ibrahim J, Bugega L, Willoughby M.et al. 2017. "Premature deaths of nursing home residents: An epidemiological analysis, Medical Journal of Australia, 206,, pp442-447.

is responsible for 15 high care residents two thirds unable to walk due to dense strokes and need lifting machines. A device you cannot use on your own. Working at these levels leads to staff breaking down due to being over worked."

Characteristics of employment in residential aged care

Gender

24. In 2016, 87 percent of the direct care workforce were female. By occupational group, 87.6% of RNs are female; 91.4% of ENs; 86.2% of PCAs and 88% of allied health workers are female. (p.17)

Age

25. The latest report notes the age of the direct care workforce is slightly younger than in previous years with the proportion of the workforce under the age of 35 increasing from 19 percent in 2012 to 25 percent in 2016.

26. The median age for all direct care occupations is 46 years, down from 48 in 2012. This is attributed to the impact of the recent recruitment of a greater number of younger people.[13]

27. Table 4 below details the median age of recently hired employees in each occupational group demonstrating the change in the age structure in 2016 compared to 2012.[14]

Table 4: Median age of the residential direct care workforce (number of years), by occupation, all direct care employees and recent hires: 2012 and 2016

	All direct care employees (Column 1)	Recent hires* (Column 2)	Difference in years in median age recent hires relative to all direct care employees (Column 3)
2016			
Registered Nurse	47	42	-5
Enrolled Nurse	50	37	-13
Personal Care Attendant	46	35	-11
Allied Health	50	33	-17
All occupations	46	36	-10
2012			
Registered Nurse	51	47	-4
Enrolled Nurse	49	44	-5
Personal Care Attendant	47	38	-9
Allied Health	50	41	-9
All occupations	48	40	-8

[13] Ibid.,15
[14] Ibid., 17

Source: Survey of residential care workers. *Recent hires have been employed for 12 months or less.

Type of employment and hours worked

28. Overwhelmingly, the direct care workforce in residential aged care is employed on a part time or casual basis (88.2%). Table 5 below shows the breakdown in employment type by occupation with 67.7% of RNs, 78.9% of ENs and 80.3% of PCAs employed on a part-time basis.[15]

Table 5: Form of employment of the residential direct care workforce, by occupation: 2012 and 2016 (per cent)

	Permanent full-time	Permanent part-time	Casual or contract	Total
2016				
Registered Nurse	22.4	67.7	9.8	**100**
Enrolled Nurse	13.4	78.9	7.8	**100**
Personal Care Attendant	8.9	80.3	10.8	**100**
Allied Health	19.9	75.3	4.8	**100**
All occupations	11.9	78.1	10.1	**100**
2012				
Registered Nurse	19.3	61.3	19.4	**100**
Enrolled Nurse	10.5	74.7	14.8	**100**
Personal Care Attendant	6.9	73.6	19.5	**100**
Allied Health	12.0	72.9	15.1	**100**
All occupations	9.5	71.8	18.7	**100**

Source: Census of residential aged care facilities.
Row percentages shown.

29. Overall, 44% of the direct care workforce is working 35 hours per week or more. By occupation, hours of work vary. For RNs, 41.8 % work 35 to 40 hours per week, as opposed to 38.2% of ENs and 31.8% of PCAs. PCAs (57.2%) and ENs (47.6%) are the most likely to be working less hours in the range of 16 to 34 hours per week.[16]

30. The report notes that a high proportion of the direct care workforce (44%) want a change in their hours of work with 30% indicating they want to work more hours. This indicates there is a significant degree of under employment and potential to increase hours of care within the existing workforce.

Current Composition of the Community Aged Care Workforce

31. The Aged Care Workforce, 2016 report, (the NILS report) also provides data on the size and composition of the direct care workforce in the community aged care sector[2]

32. The NILS report states the '2016 census estimates that total employment in home care and home support aged care is 130,263 workers, of which 86,463 are in direct

[15] Ibid., 25
[16] Ibid., 26

care roles.' [17]. Tables 6 and 7 below show firstly the headcount by occupation for the years 2007, 2012 and 2016 and secondly by Full Time Equivalent (FTE).

Table 6: Direct care employees in the home care and home support aged care workforce, by occupation: 2007, 2012 and 2016 (estimated headcount and per cent)

Occupation	2007	2012	2016
Nurse Practitioner	n/a	201	53
		(0.2)	(0.1)
Registered Nurse	7,555	7,631	6,969
	(10.2)	(8.2)	(8.1)
Enrolled Nurse	2,000	3,641	1,888
	(2.7)	(3.9)	(2.2)
Community Care Worker	60,587	76,046	72,495
	(81.8)	(81.4)	(83.8)
Allied Health Professional*		3,921	4,062
	3,925	(4.2)	(4.7)
Allied Health Assistant*	(5.3)	1,919	995
		(2.1)	(1.2)
Total number of employees (headcount) (%)	**74,067**	**93,359**	**86,463**
	(100)	**(100)**	**(100)**

Source: Census of home care and home support aged care outlets.

** Note: in 2007, these categories were combined under Allied Health.*

Table 7: Full-time equivalent direct care employees in the home care and home support aged care workforce, by occupation: 2007, 2012 and 2016 (estimated FTE and per cent)

Occupation	**2007**	**2012**	**2016**
Nurse Practitioner	n/a	55	41
		(0.1)	(0.1)
Registered Nurse	6,079	6,544	4,651
	(13.2)	(12.0)	(10.5)
Enrolled Nurse	1,197	2,345	1,143
	(2.6)	(4.3)	(2.6)
Community Care Worker	35,832	41,394	34,712
	(77.8)	(75.9)	(78.7)
Allied Health Professional*		2,618	2,785
	2,948	(4.8)	(6.3)
Allied Health Assistant*	(6.4)	1,581	755
		(2.9)	(1.7)
Total number (FTE)	**46,056**	**54,537**	**44,087**
(%)	**(100)**	**(100)**	**(100)**

Source: Census of home care and home support aged care outlets.

** Note: in 2007, these categories were combined under Allied Health.*

33. The tables show there has been a decrease in numbers in the direct care

[17] Ibid, 69

workforce between 2012 and 2016, both as measured by 'headcount' and ' full-time equivalent'.

34. Figure 2 from the NILS report[18] (Fig 5.12, p71) shows the share of occupations for the home care and home support direct care employees as both headcount and full time equivalent (FTE) in per cent of total workforce and Figure 3 shows the number of occupations in headcount and FTE[19].

Figure 2: Share of the occupations for the home care and home support direct care employees (headcount and FTE, per cent)

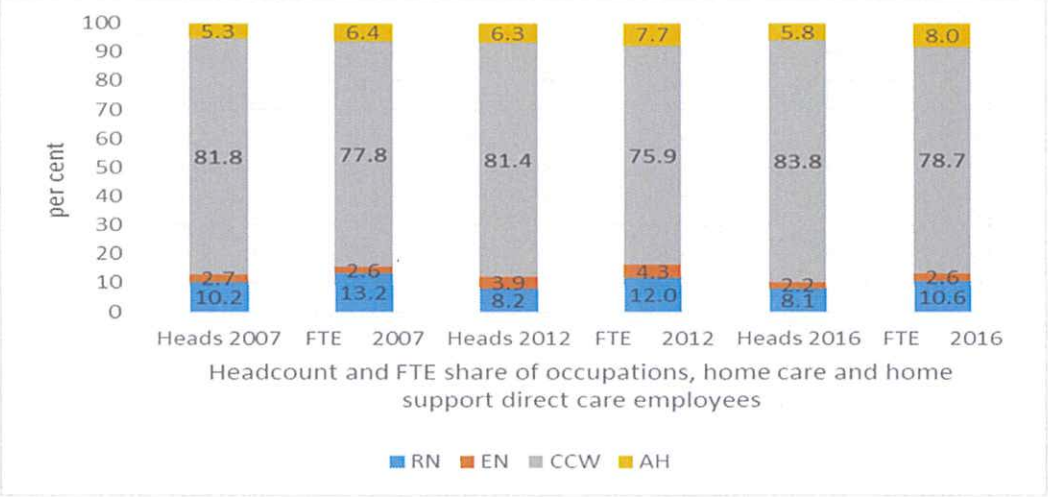
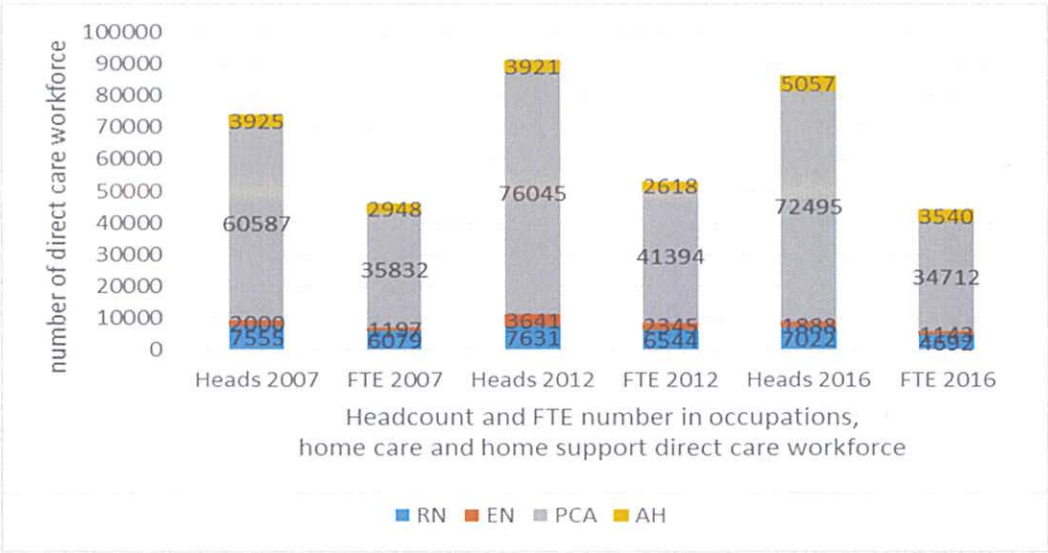


Figure 3: Number of the occupations for the home care and home support direct care employees (headcount and FTE)



Note: Nurse Practitioners and Registered Nurses were combined under 'Registered Nurse' in 2016 in Figure 5.1 and Figure 5.2. Allied Health Professionals and Allied Health Assistants were combined under 'Allied Health' in both 2007, 2012 and 2016 in Figure 5.1 and Figure 5.2.

[18] Ibid., 71
[19] Ibid

35. The NILS report data shows that the total workforce reduced in headcount size by 13% and the total headcount size in direct care by 7% between 2012 and 2016. The NILS report estimates the reduction in FTE to be 19% and also suggests the discrepancy between the reduction in headcount and FTE means there was an increase in the proportion of workers employed for fewer hours.[20]

36. The above tables show that not only has there been a reduction in the total size of the workforce, there has also been a reduction in the proportion of registered and enrolled nurses relative to the whole workforce between 2007 and 2016 and again between 2012 and 2016.

Table 4: Employees not providing direct care in the home care and home support aged care workforce, by occupation: 2016 (per cent)

Occupation	2012	2016
Care Manager/co-ordinator	33.2	29.8
Management	22.3	25.6
Administration	35.3	37.0
Spiritual/pastoral care	1.6	0.5
Ancillary care (home maintenance, modification, etc.)	7.7	7.1
Total	100	100

Source: Census of home care and home support aged care outlets.

Employment arrangements for home care workers

37. The NILS report shows the number of workers employed under permanent part-time arrangements has increased from 62% in 2012 to 75% in 2016.[21]

38. The percentage of community care workers in part time employment increased from 63% to 79% from 2012 -16.[22]

39. In 2016, across all occupations, including allied health - when casual is added - nearly 90% of workers are part time or casual.[23]

40. A significant number, 40 percent of community care workers indicated they would prefer to work more hours.[24] As with in the context of residential aged care, this indicates that there is a significant degree of under employment and

[20] Ibid.,70
[21] Ibid.,84
[22] ibid
[23] ibid
[24] Ibid.,86

potential to increase hours of care within the existing workforce.

IMPLICATIONS OF WORKFORCE DATA

41. From 2012 to 2016 the total FTE percentage of the direct care nursing workforce has reduced from 16.3% to 13.2%. Employment of registered nurses has reduced from 12% to 10.6% and enrolled nurses from 4.3% to 2.6%. As case managers are often registered nurses, or ideally should be registered nurses, it is likely that the reduction in qualified staff would potentially impact both the skills and numbers of case managers in the sector.

42. The ANMF is concerned about the reduction in overall nursing numbers and the proportional changes, as reductions in appropriately qualified care workers have direct implications for the quality and safety of the care delivered.

43. It is increasingly well documented that dilutions in the skills mix of nursing and care workforces lead to poorer health and care outcomes. A short summary of this evidence is at Attachment 1 to the ANMF's Submission ANM.0002.0001.0001[25]

44. In addition, there is also international evidence which demonstrates the improved health outcomes in community care when delivered within qualified nurse-led models. A short summary of this evidence is at Attachment 2 of ANM.0002.0001.0001[26].

Employment in residential and community aged care compared with the nursing workforce and Australian workforce

45. Table 5 below compares characteristics of the employment between the residential aged care, community care, nursing workforce in general and the Australian workforce as a whole based on 2016 data.

46. The residential and community care workforces are overwhelmingly female dominated across all classifications. In 2016, 87% of the residential direct care workforce was female[27] and in home and community care 89% of the direct care workforce was female.[28]

47. Across the three occupations, RN, EN, AIN/PCW/CCW, the community care workforce is slightly older than the residential care workforce. Nurses employed in both residential and community care are older than the average age of nurses in general. For RNs, the median age is 47 and 48 in residential and community care respectively compared to an average age of 43.9 for RNs generally. Similarly for ENs, median age is 50 and 51 in residential and community care, compared to an average of 46.1 for ENs in general. For the AIN/PCW/CCW group, the community care workforce is older than the residential care workforce – 52 compared with a median age of 46 in residential care.

48. Overwhelmingly, the residential and community care workforce is employed on a part

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[25] ANM.0002.0001.0018-0019
[26] Ibid., 0020
[27] *The Aged Care Workforce, op.cit., 15*
[28] Ibid., 74

time basis. (A significant number of employees in both the residential and community care workforce, (30% and 40% respectively), indicated they want to work more hours suggesting a significant level of underemployment in the sector). The percentage of part time employment for all nursing and carer occupations is well above the rate of the Australian workforce in general. In residential care, 78.1% of the direct care workforce is employed part time compared to 32.7% in the general community. In community care, the figure is 75.3% compared to 32.7% in the Australian workforce.

49. Additionally, full time employment is extremely low in both the residential and community care sectors. Just 11.9% and 11.2% of the direct care workforce are employed full time in residential and community care respectively. Compared to 62% in the Australian workforce.

50. The percentage of direct care employees in both residential and community care engaged on a casual or contract basis is below the general workforce figure of 25%. 10.1% in residential and 13.5% in community care.

Gender and Age comparison table

	Residential aged care (1)			**Community care (1)**			**Nursing Workforce (NHWDS) (2)**			**All Occupations (4)**
	RN	EN	AIN/PCW	RN	EN	AIN/CCW	RN	EN	AIN/PCW/ CCW	
Female	87.6%	91.4%	86.2%	93.7%	94.3%	88.8%	88.6%	90.4%	Not available	47.5%
Male	12.6%	8.6%	13.8%	6.3%	5.7%	11.2%	11.4%	9.6%		52.5%
Age	47 median	50 median	46 median	48 median	51 median	52 median	43.9 average	46.1 average		40-45 median
FT	22.4%	13.4%	8.9%	34.9%	23.8%	5.7%				62%
PT	67.7%	78.9%	80.3%	59.4%	71.5%	79%				32.7%
Casual	9.8%	7.8%	10.8%	5.7%	4.7%	15.3%	13% **(3)**	NA		25% **(5)**

Notes:

1. The Aged Care Workforce, 2016 *Mavromaras K, Knight G, Isherwood L, et al. 2017*
2. National Health Workforce Dataset (NHWDS) 2017 – (Fact Sheet 2016 data)
3. ABS 2019, customised report. Labour Force, Australia, Quarterly May 2019 for employees by paid leave entitlement status by select occupations
4. Department of Jobs and Small Business – Occupational Profiles Summary – Australia. Based on ABS data – Census of
5. Population and Housing 2016, Place of Usual Residence

ABS 6333.0 Characteristics of Employment, Australia. August 2016

51. The data in table 5 indicates the aged care workforce is older than the general nursing and care worker average. The sector needs to consider how to attract younger people into the workforce. The issues identified below at **paragraphs 70-87** in relation to education,

training and transition programs are relevant to the attraction and retention of a younger and or less experienced workforce.

52. As stated above, the data also shows that there is a high level of part-time work which indicates some workers may be underemployed and therefore there is capacity in the existing workforce that is under-utilised. This capacity should be utilised in particular as the existing workforce already has training, skills and experience.

Migrant workers in aged care

53. The ANMF does not support the international recruitment of nurses and carers by employers as a strategy to resolve 'so called' workforce shortages created by the failure to address longstanding and ongoing attraction and retention problems in the aged care sector. There is no evidence to suggest there is a *genuine* skill shortage of nurses or carers in the aged care sector nationally.

54. It is however, acknowledged that in some states and in rural and remote areas there are local shortages, making it difficult to meet appropriate staffing levels and skills mix. It is also acknowledged that permanent skilled migration has and will continue to be a source of nursing staff in aged care.

55. The ANMF supports international and domestic mobility of nurses and midwives. Both professions have a strong tradition of international collaboration and employment, moving around the globe to gain further training, different clinical and professional experiences, and to provide valuable care to vulnerable populations during humanitarian crises. There is also clear merit in international exchange and cultural diversity, as well as the economic benefit of remittances and transfers in technologies.

56. We recognise that in many cases the motivation to work in other countries is linked to more and better employment opportunities, higher salaries, better working conditions and improved capacity for career advancement. Increasingly the opportunity to work and live in a better and safer environment for themselves and their families is an important factor.

57. Our union generally favours permanent migration but recognises there is a place for temporary skilled migration programs where there is evidence of a *genuine* short term and unexpected domestic skill shortage.

58. In addition, our acceptance of the need for temporary skilled migration is conditional on the implementation of policy and regulatory arrangements that discourage employers accessing offshore labour without first investing in training and undertaking genuine testing of the local labour market. These arrangements must also provide safeguards and protections for both local and overseas workers to ensure decent wages and conditions of employment and prevent exploitation in the workplace.

59. The ANMF advocates for the ethical recruitment of offshore nurses and midwives. The ANMF policy on the international recruitment of nurses and midwives is annexed to this submission and marked **ANM.0013.0002.0001**.

60. We also understand the need for international students to have the ability to earn an income while studying to meet their living expenses and course fees.

61. Nursing features strongly in Australia's skilled migration programs including the Temporary Skill Shortage visa (subclass 482) program (and the former subclass 457 program) as well as other temporary and permanent visa grants. Since 2012-13 registered nurses have been one of the top five occupations granted permanent visas under the General Skilled Migration (GSM) scheme.

62. In tables 6 – 10 below we set out data on holders of visa subclass 457/482 and numbers granted to overseas nurses from 2010 to 2019 for registered nurses in general and separately for Registered Nurses (Aged Care). Please note that since the introduction of ANZSCO in 2010 (formally ASCO) there are 14 registered nurse occupational categories which international nurses can be nominated under including Medical, Aged Care, Educator, Nurse Practitioner, and Community Health.

Table 6: Number of subclass 457/482 visa holders snapshot dates 2010 to 2019

Registered nurses (2544)	Sept 2010	June 2011	June 2012	June 2013	June 2014	June 2015	June 2016	June 2017	June 2018	June 2019
457	3472	3171	3925	4260	3637	2540	1998	1833	1960	1197
482	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	92	977

Source: Australian Government, Department of Home Affairs: https://data.gov.au/dataset/visa-temporary-work-skilled

Table 7: Registered Nurses (Aged Care) Number of subclass 457/482 visa holders snapshot dates 2010 to 2019

Registered nurses (aged care) (254412)	Sept 2010	June 2011	June 2012	June 2013	June 2014	June 2015	June 2016	June 2017	June 2018	June 2019
457	74	344	765	995	857	611	475	450	481	302
482	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	9	190

Source: Australian Government, Department of Home Affairs: https://data.gov.au/dataset/visa-temporary-work-skilled

Table 8: Number of subclass 457/482 visa grants financial year 2005-06 to 2017–18 and to June 19

Registered nurses (2544)	2005-2006	2006-2007	2007-2008	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-19 to June 19
457	2609	3011	3375	3977	2624	2146	3095	2853	1489	993	1009	1074	1028	78
482	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	116	1060

Source: Australian Government, Department of Home Affairs: https://data.gov.au/dataset/visa-temporary-work-skilled

Table 9: Registered Nurses (Aged Care) Number of subclass 457/482 visa grants financial year 2005-06 to 2017–18 and to June 19

Registered nurses (aged care) (254412)	2010-2011	2011-2012	2012-2013	2013-2014	2014-2015	2015-2016	2016-2017	2017-2018	2018-19 to June 19
457	382	632	612	337	248	241	265	241	19
482	n/a	n/a	n/a	n/a	n/a	n/a	n/a	11	202

Source: Australian Government, Department of Home Affairs: https://data.gov.au/dataset/visa-temporary-work-skilled

63. The numbers of Enrolled Nurses (411411) holding a temporary resident (skilled) visa are low with just over 50 as at June 2017-18 and 22 at June 2019.

Table 10: International nursing student enrolment count (General nursing course required for initial registration) 2010 to 2017

Enrolment Count	2010	2011	2012	2013	2014	2015	2016	2017
Overseas	6,825	6,959	6,832	6,780	6,878	7,466	8,168	9,078

Source: Department of Education. Higher Education Statistics Data Cube (uCube) https://www.education.gov.au/ucube-higher-education-data-cube

64. It is worth noting that student visas include a visa condition that, once the course has commenced, students may work for up to 40 hours per fortnight while their course is in session and for unlimited hours during course breaks.

65. An additional visa, the Temporary Graduate visa (subclass 485), allows an overseas student to work in Australia temporarily after graduation. This visa is for international students with an eligible qualification who graduate with skills and qualifications that relate to an occupation on the Skilled Occupation List, which includes nursing and midwifery graduates.

66. Overall the work rights provided to temporary visa holders in nursing under subclass 482/457, and subclass 485, along with international students and working holiday makers, constitute a significant migrant workforce that has an impact on the domestic nursing labour market including in the aged care sector.

67. Nurses with temporary work visas are employed across all sectors of health, community and aged care. Residential aged care and private hospital employers employ the bulk and they are also widely employed in state and territory public sector facilities. International students feature strongly in the residential aged care sectors where they are employed in care-worker roles during their undergraduate studies.

68. As outlined in the Royal Commission into Aged Care Quality and Safety Background Paper 2, immigration may offer some assistance in addressing skill shortages in aged care workforce. However, in addressing Australia's future aged care workforce needs, it will be important to remember that demand is not seasonal and is not subject to changes due to economic conditions. Its growth is primarily driven by demographics. It is therefore better suited to being staffed by a stable, long-term workforce than a temporary migrant workforce with high turnover or workers staying for long periods but with limited rights. For example, Callister et al have argued that 'Aged-care clients are a vulnerable group and

if they are looked after by another vulnerable group, without the protection of permanent residency or citizenship, this may impact on quality of care.[29]

EDUCATIONAL PREPARATION AND TRAINING PATHWAYS FOR THE AGED CARE WORKFORCE

69. In understanding the aged care workforce's capacity and capability to provide high quality care and support good quality of life to care recipients, the educational preparation and training pathways for the workforce must necessarily be considered.

70. In Australia, the aged care nursing and personal care workforce comprises three categories of worker; two categories are qualified professional nurses, the registered nurse and the enrolled nurse, with the third category being an unregulated care-worker. These workers are further supported by nurse-practitioners, who are registered nurses with post-graduate education at Master's level and are clinical experts in a specific area of practice.

71. The ANMF's submission to the current Independent Review of Nursing Education – ***Educating the Nurse of the Future*** (annexed and marked **ANM.0013.0003.0001**) provides a detailed overview and analysis of the education of registered and enrolled nurses, and nurse practitioners. The submission assesses the effectiveness of the current education of nurses, including articulation between the three levels of nurses, and provides an analysis of the current shortcomings of nursing education. The submission further proposes strategies that the ANMF recommends are required to address the deficiencies we have identified in the system. We refer the Commission to the attached submission for this information.

72. Given the above, the remainder of this section focuses on the educational preparation of care-workers as well as the issues related to nursing and care-worker education as they specifically apply to the aged care sector.

Educational preparation of care workers

73. A care worker, (however-titled, e.g. personal care worker, assistant in nursing) is an unregulated worker who provides aspects of nursing care and personal care in the community or in residential facilities. There is currently no regulated minimum education requirement for care workers. It is estimated that 67% of care workers[30] have a Certificate III in aged care while the remainder possess no formal educational preparation for care delivery. Care workers who do not have a Certificate III may have a level of 'on the job training' being delivered by providers, however this training is not consistent or regulated, in theory and/or practice delivery.

74. The Certificate III in Individual Support, the principal qualification for preparation to work in the aged care sector, provides baseline training for a care worker in attending activities of daily living, emotional support and observational skills. It introduces care workers to the aged care sector and care delivery. Ideally it should be conducted over a minimum of nine months with a mix of theory and work place experience, including workplace

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[29] P Callister, R Didham and JBadkar, *Aging New Zealand: The Growing Reliance on Migrant Caregivers, a 2014 Update*.Working paper, December, Callister & Associates, Wellington New Zealand,2014.

[3030] Nils report

placements which amount to a total of 120 hours.

75. However, there are a number of issues with the qualification, which predominantly relate to its delivery. There are sector wide concerns about the current theory (which is currently under review), content and work placement delivery, the lack of regulation of the program and, for some programs, the adequacy of student learning outcomes. There are examples of the program being delivered in significantly shorter time than the identified minimum nine months. There are also considerable inconsistencies in theoretical inclusions and the quality of workplace placements across the sector.

76. The ANMF has received wide feedback from both aged care nurses and workers and from industry that the program in many instances is not meeting the requirements for the role of a care worker due to inconsistencies with its delivery. We receive frequent reports that the care workers who have completed a program have not gained the required skills and knowledge the qualification is designed to deliver. They lack the requisite skills for dealing with elderly people and the specific conditions of ageing, even at Certificate III level , and many do not possess first aid skills even though they are very often likely to be the first responder in a residential aged care setting.

77. The Aged Services Industry Reference Committee (IRC) is currently undertaking a review of the current aged care program and related qualifications for work in aged care. We refer the Commission to the statement of Rob Bonner, Deputy Chair, Aged Services IRC for the details of this work.

Regulation of education programs and care workers

78. To ensure that people receive quality care, minimum standards must be set in place and consistent across the Vocational Education and Training (VET) and aged care sectors. Nurses are regulated health professionals and have clear minimum standards in place. However, care workers currently do not have effective regulatory requirements. They are not required to work in accordance with any professional standards and they do not have an effective process for managing complaints. Care workers do not have a minimum education requirement for entry to work in the sector, they do not have to maintain regular professional development or need to have professional indemnity insurance.

79. As care workers are not individually regulated or licensed, there is no requirement for the Certificate III in Individual Support program (or related qualifications) to be accredited by a national registering authority as must occur with programs leading to registration as a nurse. Instead, this qualification requires a single layer of regulation by the Australian Skills Quality Authority (ASQA), which, as has been outlined above, is not ensuring consistent and reliable outcomes across the sector nor is it ensuring the production of workers with the appropriate knowledge and skills to work effectively in the sector.

80. Additionally, as there is no national registering or licensing system in place for care workers, consumers, families or employers cannot check whether the care worker is appropriate to be looking after them or their loved one. This is compounded by the fact that many care workers are working independently, such as in the home environment. Currently, if a care worker is found to be unsafe in the care they provide and is dismissed from their employment, they can move onto another employer with a minimal checking process occurring or, on many occasions, without any process at all.

81. The difficult circumstances for many care workers created by the lack of appropriate

regulation around their work is currently exacerbated by the lack of qualified nursing staff in the aged care workforce. This has resulted in many employers placing excessive demands on care workers both in terms of workloads but also in terms of the level of care employers expect them to provide. They are expected to perform activities, which should be conducted by qualified nurses such as medication management and wound care, despite lacking the required underpinning knowledge and skills to perform these activities safely. This places both the workers and those in their care at unnecessary risk.

82. While the current educational preparation for care workers in the aged care sector is clearly insufficient, the ANMF argues that in some cases the system has been structured to provide a carer workforce that can be kept compliant, in insecure work and therefore, low paid, rather than to meet the care needs of older Australians. It is abundantly clear that this issue requires urgent attention.

Articulation between qualifications

83. As outlined above, articulation between Diploma, Bachelor and Masters level nursing programs is discussed in detail in the ANMF's submission (education submission) to the current Independent Review of Nursing Education – *Educating the Nurse of the Future* (**ANM.0013.0003.0001**). This section therefore focuses on the articulation of Certificate level courses to higher and nursing courses and pathways into the aged care sector.

84. The Certificate III in Individual Support (CHC33015) qualification articulates well to the Certificate IV in Ageing Support (CHC43015), within the processes and policies housed within the Community Services Training Package which includes recognition of prior learning. If a care worker chooses to move into the nursing profession and they possess a Certificate III level qualification they are able to articulate into the Diploma of Nursing, which, as outlined in the ANMF's education submission, articulates into the Bachelor of Nursing.

85. The challenges noted in the education submission in the articulation between the Diploma of Nursing and the Bachelor of Nursing programs are not insurmountable. The established difference between the two sectors (vocational and higher education) enables the nursing profession, with the two levels of nursing, to work effectively and enables a clear and distinct scope of practice between the two levels. This difference can be celebrated rather than seen as a problem. Many universities have already solved the challenge of articulation and have in place agreed approved entry pathways for enrolled nurses into the Bachelor of Nursing.

86. Articulation between the Certificate III in Individual Support and related programs could be significantly improved through regulation of care-workers as this would ensure a consistent minimum educational attainment for entry to practice. As this would establish a clear educational baseline it would allow much smoother articulation into nursing and other health professional qualifications, as well as into higher level certificate qualifications in relevant training packages.

Regulation of the aged care workforce

87. The ANMF refers to its previous submission ANM.0006.0001.0009-13 with respect to regulation of the workforce.

SKILLS AND PERSONAL ABILITIES OF THE AGED CARE WORKFORCE

88. In discussions of the aged care workforce, the need to ensure employment of the 'right' people, that is people with the 'right' attitude, is frequently raised, predominantly by aged care employers. The ANMF does not disagree, however we continue to maintain that the need to ensure employment of workers with the 'right' attributes for work in aged care must not override the need to employ sufficient numbers of appropriately qualified staff. Until this is achieved aged care workers, even those possessing the best attributes, will not be supported or enabled to provide safe, quality care. The following section outlines the ANMF's views on the skills and personal abilities required by the aged care workforce.

89. In aged care, the 'right individual with the right fit' can be described as an individual with the appropriate attitude and aptitude to work in the sector.[31] The ANMF believes that these qualities are possessed by individuals who are morally committed to the provision of holistic, high quality care to vulnerable sectors of the community. The individual's ability to deliver and further develop this care is reliant on appropriate resourcing and support.[32] Where this support is not provided, the development and quality of these individuals is inhibited. The current systemic problems in aged care, such as poor staffing, lack of employer support, and insufficient remuneration may lead to individuals with strong personal commitment to the provision of safe, quality care to burn out and/or leave the sector due to frustration with not being able to provide a high standard of care they expect of themselves and know that their residents deserve. As members told us in the 2019 ANMF National Aged Care Survey:

"My facility brought in staffing cuts over a year ago as profits were down to unsustainable levels. As a result, the facility has gradually gone downhill. Staff are beyond exhausted. Morale is extremely low. Residents are completely aware and deserve more. When us staff approach management to complain and request more staff we are good this is how it is, deal with it. The only reason most of us stay is we truly care and worry for our residents if we leave."

"Please advocate and get changes needed. I am trying desperately hard to get back into the hospital acute sector [because] *in aged care... I no longer feel safe in this sector. If I don't make it, I will leave nursing altogether. Many of my colleagues have left and it's a shame as we are very experienced and skilled in this area and very supportive of junior staff."*

"I left the last aged care facility be sure Management decided to increase the workload of nurses by including food prep, cleaning and activities into our job description, simply to cut staff levels even further. I could not cope with the inability to provide adequate care to the residents. I no longer work in aged care and will never again while the issues remain the same."

"I am about to resign after nearly 30 years in Aged Care directly due to recent cuts in RN hours resulting in what I consider to be unsafe work conditions i.e. I feel that my practice is compromised."

"I worked in a dementia specific nursing home for 2.5 years as a PCA. The reason I left was due to management cutting staff, increasing workloads, limiting the ability to provide the best quality car that we wanted. Working in in-home (Community) care is better from a staffing perspective, but not without other issues, particularly OHS and repetitive heavy manual work such as 4 house cleanings in a day."

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[31] Ibid [1]
[32] Ibid [11]

90. Finding and retaining the right people with the right characteristics, aptitudes, and skill-sets to work in the aged care sector is described in the terms of reference for the Aged Care Workforce Strategy Taskforce.[33] The ANMF understands that defining the 'right' person with the 'right' fit will vary depending upon perspective (e.g. employer, employee, care recipient, or community member), broadly, however, a particular skill set is required to deliver quality care within the healthcare industry. These skills are particularly important within the aged care context where systemic industry problems are driving a decreased quality of care for residents and consumers and leading to poor worker attraction and retention.[34]

91. An integrated review identified five areas required for the appropriate delivery of care in aged care nursing; ethical and attitudinal, interactional, evidence-based care, pedagogical, and leadership and development competence.[35] Each of these are covered under the NMBA's regulatory standards for registered and enrolled nurses, however no comparable regulatory standards exist for personal care workers.[36] The ANMF believes these skills are equally necessary across all levels of care provision within the aged care sector.

92. Ethical dilemmas occur frequently within aged care facilities. A possible example could occur where policies and procedures enacted to ensure the overall wellbeing of an individual are in conflict with an individual's personal preference for care. In this situation, a care giver is required to respect the privacy, individuality, and choice of the care recipient whilst ensuring that appropriate and evidence-based care is delivered in-line with established regulations and standards.[37] These decisions must be managed at both the individual and collective level, where the dignity of one person must be respected whilst ensuring quality of life for all other individuals within a facility. This is achieved through an attitudinal willingness to understand and respect the feelings and needs of older people whilst maintaining disciplined and ethical decision-making.[38]

93. Effective communication, interaction, and collaboration between and among staff, recipients of care, and their families is vital in aged care. Aged care staff must be capable of communicating respectfully and empathetically in often sensitive situations, potentially involving end-of-life care. This expectation also extends to working as a member of the broader care team; an environment in which communication skills are crucial to the successful delivery of quality care.[39]

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[33] Aged Care Workforce Taskforce. 2018. A matter of care: Australia's Aged Care Workforce Strategy - Report of the Aged Care Workforce Strategy Taskforce [Internet]. Commonwealth of Australia, Department of Health. Canberra, ACT. Available online: https://agedcare.health.gov.au/aged-care-workforce-strategy-resources

[34] Kiljunen O, Välimäki T, Kankkunen P, Partanen P. Competence for older people nursing in care and nursing homes: An integrative review. International Journal of Older People Nursing. 2017;12(3):e12146.

[35] Ibid.

[36] NMBA. 2019. Professional Standards. [Available from: https://www.nursingmidwiferyboard.gov.au/Codes-Guidelines-Statements/Professional-standards.aspx

[37] Advisor CT. Dealing with Ethical Dilemmas: HCPro; 2014 [Available from: https://www.advanced-healthcare.com/wp-content/uploads/2011/07/December-2014-Inservice.pdf.

[38] Ibid [2]

[39] Ibid [2]

94. Technical skill and current knowledge of evidence based best-practice is required for the delivery of care to residents. Aged care staff are often required to decide upon and deliver this care independently or under the direction of more senior or qualified staff. Successful delivery of this care requires an understanding of the individual receiving care and will incorporate proactive assessment of health and wellbeing.[40]

95. Pedagogical competency is required by senior staff across all levels in supervising and educating less experienced staff to acquire and master new knowledge to drive best practice. This skill is also important when reassuring residents or family in care planning processes. Skill in education is an important tool in building trust and alleviating anxiety or fear.[41] This skill is also particularly important in terms of supervising and training new staff and students on placement.

96. Competency in leadership is expected where aged care staff, particularly those in senior roles, are required to plan, organise and manage resources in often intense work environments. The requirement to lead is often derived from necessity and expectation.[42] While registered nurses are often the best placed to lead care in residential aged care facilities, leaders do not necessarily hold managerial roles in aged care or hold a particular qualification. Opportunity for education and support in the development of leadership is often found to be lacking across the aged care industry and is a key area for further improvement.[43]

97. The skills and abilities outlined above present the ANMF's view of the ideal requirements for work in the aged care sector. However, as stated earlier, the current conditions across the aged care do not promote, foster or develop the required skills and abilities for work in the sector. Employers have a duty to look after and support their staff and to engage in ongoing training to improve their skill and confidence to provide safe and effective care. However, this is currently not occurring across the sector, leading to a workforce which is not equipped, either in numbers or appropriate skills, to ensure safe and quality care for all elderly Australians. The next section of this submission examines, in greater detail, why this is the case.

CHALLENGES IN ATTRACTING AND RETAINING AGED CARE WORKERS

98. As stated above, the provision of safe and quality aged care in Australia demands a sufficient and suitably skilled workforce. The previous section in this submission outlined the current size and composition and noted the changes in the skills profile of the workforce over the last 15 years. These changes have resulted in a workforce which is insufficient to meet the current care needs of elderly Australians.[44] A range of challenges in attracting and retaining aged care workers has been a major contributor to the current insufficiency of the aged care workforce.

99. The problems with attraction and retention of the workforce in the aged care sector are

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[40] Ibid
[41] Ibid
[42] Ibid
[43] Dwyer D. Experiences of registered nurses as managers and leaders in residential aged care facilities: a systematic review. International Journal of Evidence-Based Healthcare. 2011;9(4):388-402.
[44] Willis E, Price K, Bonner R, et al, op.cit., 99-101

not new. The challenges, broadly outlined below, are well understood across the industry:

- low wages and poor conditions;
- inadequate staffing levels and workload issues;
- unreasonable professional and legal responsibilities;
- lack of career opportunities;
- stressful work environments;
- poor management practices; and,
- a poor perception of aged care in general.

100. Despite this understanding, governments and industry have simply failed to address these matters. Consequently, these issues continue to persist. These issues, and the reasons for them are outlined in detail in the next sections of this submission.

WAGES AND THE INDUSTRIAL LANDSCAPE IN AGED CARE

Industrial Overview

101. Workplace wages and conditions are key to attracting and retaining suitably skilled and qualified workers to the aged care sector. Unlike public and private sector health, the aged care sector is not as well developed industrially and this has affected wage and condition outcomes. Poor conditions and low wages also contribute to the perception that work in aged care is undervalued, under-appreciated and not respected. To attract and retain skilled and experienced staff into the aged care sector and enhance the workforce's capacity and capability to provide high quality care, wages and conditions must improve.

102. In a recent ANMF survey of members who have left or are thinking about leaving jobs in aged care, just over 44% (n = 341) participants indicated that "low wages" were a primary or contributing factor to their decision to leave. Among participants who currently work in aged care, just over 62% (n = 505) indicated "low wages" were a primary or contributing reason for considering leaving the sector. "Improved pay" (76%/ n = 1,138) was the third most commonly selected factor that participants identified would influence them to continue to work in aged care or return to working in aged care behind "minimum staff to resident ratios" (78%/ n = 1,165) and "more time with residents" (80%/ n = 1,183). Below are selected quotes from members where they discuss the impact and experience of low wages in the sector:

"There has to be more money for wages for qualified staff that are compatible to gov sector. People can't do the hard work with no financial benefits."

"I used to work in aged care full time. I left to work in the hospitals as nearly $22hr more – YES $22 an hour. The entire sector is a joke many of these places are beautiful to look at but it stops there. Having 34 years-experience in the sector they are all the same disgusting workloads, pitiful wages, lack of resources..."

"Every shift is a struggle, not enough staff, time or resources. Unpaid overtime has become a regular occurrence and management don't care. We are constantly told to "work faster, work smarter"

"Instead of the government giving us as an industry a bad wrap all the time, provide us with the means as in wages and ratios to make the industry great again."

"We are under-valued, and this is reflective in our wages. I can apply for and work as a disability support worker/teacher aide in a position that is from only 0800-1330 Monday-Friday for double the rate I'm currently on now including the penalties I get now. The new position on base rate is more than my 75% penalty rate I get on a Sunday in aged care and I would have my weekends free! ..."

"I do an important job, we are responsible to make sure someone's loved one is kept safe, feed, bathed, and given the care that every human has a right to. Yet care workers wage is less than a person the stack shelves [at a supermarket]! How's is this right? The award rate needs to be looked at."

"The owners of the Nursing Home are "crying poor" whilst making millions of dollars profit, and cutting wages, shifts & the standards of care. QLD nurses are paid the lowest of any State there needs to be standardisation of wages & conditions across all States in Australia."

"I really would like to see something done; certainly better wages and more staff should be at the top of the list. Our elderly have given all their life and now should be better looked after."

Wage outcomes

103. A report prepared for the Aged Care Workforce Strategy Taskforce[45] analysed remuneration levels of PCW and nursing roles in the aged care sector comparing like for like roles from their pay database which contains remuneration data for 463 organisations nationally across all major industry sectors.

104. The remuneration measure used is "Fixed annual reward" (FAR) – base salary plus fixed allowances and benefits, plus employer superannuation and NFP gross up, but excludes short-term incentives. The data set out below is as at February 2018.

105. The key findings show that:
    - PCWs are paid significantly below the market medium. PCWs are generally paid between the bottom 10% and bottom 25% of the "All Organisations market".[46]
    - Nurses – overall the FAR of Nurses in aged care is lower than the median FAR of similar size roles in the "All Organisations market".[47]
    - Nurses at Hay Reference Levels, (job levels), 11 to 14 are paid between the 25th percentile to the 50th percentile of the All organisations market.
    - Nurses at Hay Reference Levels 15 to 16 are paid below the 25th percentile of the All organisations market
    - For nurses, incremental progression in salaries between levels are insignificant compared to the market implying that as the job progresses, it tends to fall behind the market for comparable higher-level jobs.

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[45] Korn Ferry|Hay Group, Reimagining the Aged Care Workforce Report prepared for the Aged Care Workforce Strategy Taskforce Australian Government by Department of Health, 2018.
[46] Korn Ferry|Hay Group, 97
[47] Korn Ferry|Hay Group, 98

Comparison with specific industry markets:

106. The report found that care workers in aged care had an overall FAR that was significantly lower than in comparable markets and nurses were also lower. The report concluded:

107. "The findings of this remuneration benchmarking support the idea that remuneration might be a key obstacle in attracting the right talent to the aged care industry. ...."[48]

108. As highlighted above from the results of our recent survey, our members agree that poor wages are a considerable problem.

The role of Federal awards

109. While enterprise agreements are the predominant form of industrial regulation covering nurses and care workers in residential aged care, approximately 10% of facilities are award reliant.

110. In home and community care the level of award reliance is much higher due to the difficulty in organising this more fragmented workforce and the lack of enterprise bargaining in this area. The *Nurses Award 2010*[49] and the *Aged Care Award 2010*,[50] together with the National Employment Standards, provide a minimum safety net of wages and conditions of employment for nurses and care workers.

111. The most recent process of award modernisation involved the review and rationalisation of more than 1500 awards into 122 industry or occupational awards.

112. For nurses and nursing employers it meant approximately 50 federal awards and 80 state awards were merged into a single occupational award covering all national system employers of registered nurses, enrolled nurses and assistants in nursing, however titled, except primary and secondary schools.

113. This process meant a reduction in wages and conditions for many employees in the aged care sector, particularly those previously covered by state awards where wages had been subject to work value increases and conditions periodically adjusted to reflect changes in community standards.

114. The second major modern award review, (the four-yearly review) commenced in 2014 and continues into 2019. While the four yearly review process has resulted in some beneficial improvements to the awards, it has not been concerned with reviewing minimum rates of pay or how those rates are set.

115. Award rates for nurses and care workers are substantially lower than public sector rates and are lower to varying degrees for nurses and care workers covered by enterprise agreements in non-public sector aged care.

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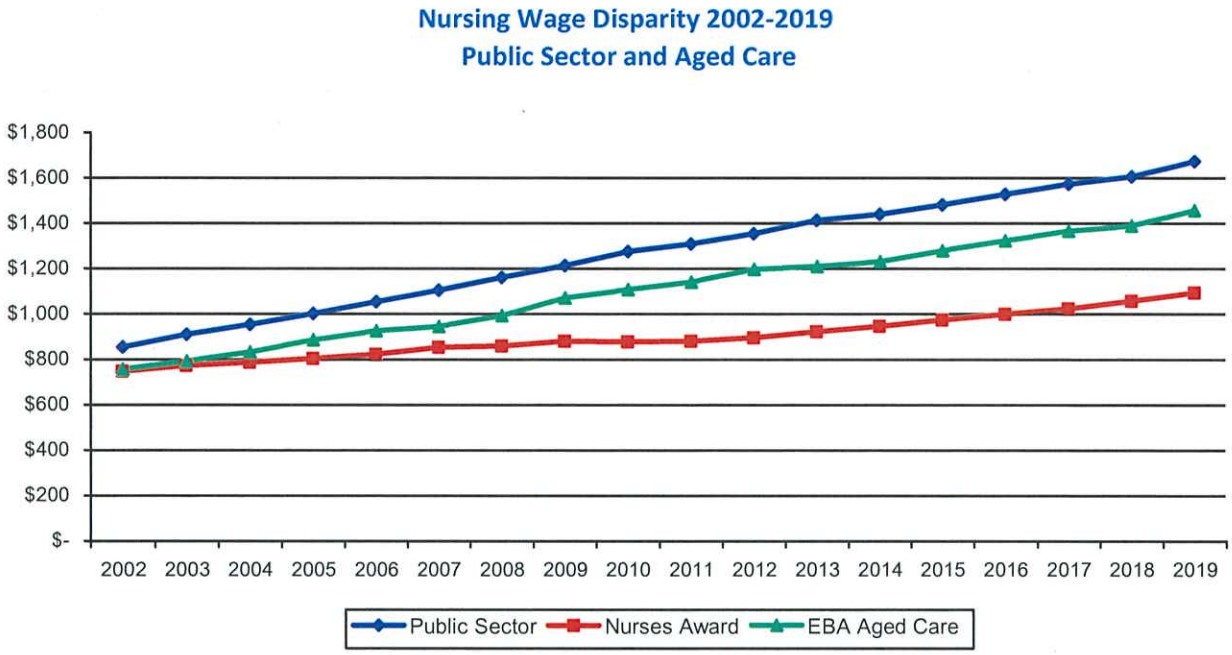
[48] Korn Ferry|Hay Group, 104

[49] https://www.fwc.gov.au/documents/documents/modern_awards/award/ma000034/default.htm

[50] https://www.fwc.gov.au/documents/documents/modern_awards/award/ma000018/default.htm



116. The low benchmark of award rates is a factor that influences poor enterprise bargaining outcomes in private profit and not for profit aged care.

117. Modern awards also play an important role in agreement making, providing the basis of the "better off overall test" under the *Fair Work Act 2009*. This requires employees covered by an agreement to be better off overall than they would under the relevant modern award. Awards are therefore important in providing a safety net for negotiating enterprise agreements.

118. Many award entitlements have monetary values set around base ordinary hour rates, for example shift penalties, overtime, weekend and public holiday rates and superannuation. Where base rates are low, all consequent rates are also low, thus compounding the impact of working in a sector that does not compare favorably with public sector health.

The role of enterprise bargaining

119. Currently, the vast majority of nurses and care workers' wages and conditions are established through the process of enterprise bargaining. It is almost universally the case that the ANMF is a bargaining representative in negotiations with the respective employers.

120. Excluding government aged care facilities, as at August 2019 there are approximately 754 federally registered agreements operating in the sector covering an estimated 2137 facilities. 87% of the agreements cover all nursing categories, including RNs, EN's and AINs/PCWs. The remaining agreements cover nursing staff or care work staff only.

Agreement coverage

121. Agreement coverage varies across states and territories. For example, in Victoria 96% of

facilities are fully covered by agreements; 95% in NSW, 92% in Tasmania and 78% in Queensland. In South Australia coverage is more variable depending on classification. RNs and ENs are covered by 98% of facilities while only 43% of facilities are covered by an agreement for AIN's/PCWs.

122. In the main, agreements are state based covering single employers and employees of a particular enterprise. A number of large providers, have multiple agreements covering employees in different states. This can result in different wages and conditions applying to employees working for the same employer and doing the same or comparable work.

123. There is a small number of agreements operating across two, three or more states or territories.

Wage outcomes in aged care enterprise bargaining

124. The ANMF produces a quarterly report[51] on average wage data based on current and recently expired (or recently passed their nominal expiry date) agreements for key classifications including:

> AIN/PCW; AIN/PCW certificate III; Enrolled Nurse and Registered Nurse Level 1 (or equivalent).

125. The data is provided on both state/territory and national level and compared with equivalent classifications in the respective public sector agreements/awards to identify the disparity in rates for each classification.

126. Nationally, and on average, the rates of pay for an RN level 1 sitting at the top of the structure are 15% or $216 per week less in aged care compared to public sector wages.[52] This is calculated on the base rate of pay and does not take into account other wage based entitlements such as shift allowances, weekend penalties, qualification allowances and so forth, important to overall remuneration. As stated above, a low base rate impacts on the rate of other entitlements.

Aged Care Average wages data – August 2019

127. Bargaining outcomes are fragmented with varied wage rates both within and across the States and Territories and also across classifications.

128. The exception is NSW where a large percentage of the sector is covered by agreements based on two different templates negotiated with the industry bodies.

129. The average wages data below is indicative of wage levels for key classifications and shows the degree of variation between States/territories.

Rate ranges by classification:

Classification	National average	Lowest	Highest
AIN/PCW entry	$22.29	$21.75	$23.58

[51] Paycheck
[52] Paycheck

AIN/PCW thereafter	$23.32	$22.40	$24.26
AIN/PCW Cert 3 entry	$23.69	$22.90	$24.31
AIN/PCW Cert 3 thereafter	$24.03	$23.09	$24.90
EN min	$26.39	$25.18	$28.10
EN max	$29.27	$28.59	$31.23
RN level 1 entry	$30.62	$26.15	$33.12
RN level 1 max	$38.43	$31.29	$41.67

Rates by classification and state/territory

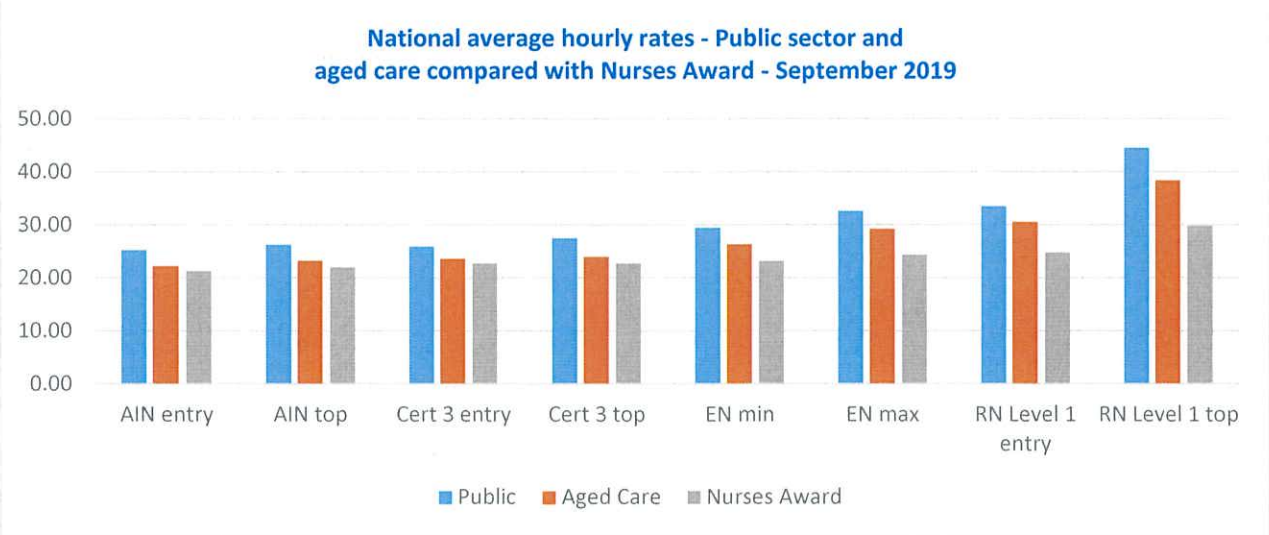
	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	AUST
AIN/PCW entry	$21.75	$23.26	$22.28	$21.79	$23.58	$21.85	$21.95	$21.97	$22.29
AIN/PCW thereafter	$23.27	$23.84	$22.90	$22.40	$24.26	$22.42	$22.56	$23.68	$23.32
AIN/PCW Cert 3 entry	$23.53	$24.28	$23.47	$22.90	$24.28	$22.92	$24.31	$23.64	$23.69
AIN/PCW Cert 3 thereafter	$23.61	$24.90	$23.88	$23.58	$24.83	$23.09	$24.77	$23.97	$24.03
EN min	$27.20	$25.72	$26.23	$25.18	$27.18	$26.49	$25.40	$28.10	$26.39
EN max	$29.78	$29.10	$28.59	$28.79	$29.02	$28.87	$29.68	$31.23	$29.27
RN level1 entry	$32.33	$29.65	$30.33	$27.63	$33.12	$28.11	$26.15	$33.08	$30.62
RN level 1 thereafter	$40.64	$36.52	$36.16	$37.58	$41.67	$37.18	$31.29	$40.15	$38.43

Nurses Award rates of pay

130. Award rates of pay are extremely low. The Table below shows that for AINs/PCWs in particular, aged care agreement rates (on average) are only 6-8 percent above the Award. Rates for equivalent classifications in the public sector are 18 to 26% above the Award.

National average rates of pay compared to Nurses Award

Classification	Public Sector	Aged Care	Nurses Award	% Diff public sector & Nurses Award	% Diff Aged care & Nurses Award
AIN entry	25.21	22.29	21.23	19%	5%
AIN top	26.26	23.32	21.99	19%	6%
Cert 3 entry	25.88	23.69	22.70	14%	4%
Cert 3 top	27.47	24.03	22.70	21%	6%
EN min	29.43	26.39	23.12	27%	14%
EN max	32.61	29.27	24.32	34%	20%
RN Level 1 entry	33.49	30.62	24.73	35%	24%
RN Level 1 top	44.49	38.43	29.72	50%	29%



131. While there is a high level of bargaining in the sector, the results have always been and remain patchy, and below most other sectors. The disparity in wage rates is compounded by less attractive conditions in relation to workload, leave and other entitlements.

132. This is a key factor in recruitment and retention of skilled staff in the sector and will remain the case until the substandard wages and conditions for all staff are addressed.

Barriers to strong bargaining outcomes in aged care

133. Bargaining in this sector has always been difficult and remains so today. From its inception in the mid 1990's it has been a struggle to secure decent wages, wage increases and improved conditions for nurses and carers working in aged care through bargaining.

134. A number of factors, as outlined in detail below, contribute to the problem.

High levels of part-time and casual employment

135. As set out in **paragraphs 29 and 39** the overwhelming majority of the direct care workforce in residential aged care is employed on a part-time or casual basis. The high proportion of part-time and casual staff in aged care contributes to the problems in bargaining in a number of ways. There is also reticence on the part of employers to give casual staff members permanent hours despite consistent employment, as a member told us in the 2019 ANMF National Aged Care Survey:

> *"40 years-experience and training and paid less than a supermarket shelf stacker. Expectation to do heaps of (usually online tick and flick training) while not being given permanent hours after two years in my current workplace as a casual."*

136. Staff spend less time in the workplace and may do shift work that means they are not present when staff meetings or union meetings take place. It is difficult to organize when the workers time at the workplace is variable or irregular.

137. Employees engaged on either in casual employment or part-time employment are

vulnerable to losing shifts. This contributes to a reluctance to be vocal or active in the workplace. A member told us in our recent workforce retention survey:

"Food being served to residents was disgusting, when I complained I was labelled a troublemaker and had my hours cut"

Female dominated workforce

138. Historically, female dominated workforces are undervalued and have been less industrially organised than male dominated industries. This has resulted in long term, systemic undervaluing of work in female dominated industries - for example in child care, early childhood education and the disability sector. Aged care is no exception.

139. The majority of the aged care workforce is female with an average age of 46. The combination of the factors above and the high proportion of part-time and casual work positions the aged care workforce as vulnerable to systemic issues. In addition, as females, many workers have caring responsibilities outside of work and rely on shift work to manage those responsibilities.

140. The 2012 Equal Remuneration Case[53] in relation to the *Social Community Health and Disability Award* (SCHADS Award) resulted in uplift to award rates over a period of 8 years by between 23% and 45%. The female dominated work in aged care would have many comparable features to that of workers employed under the SCHADS Award and indeed some workers in aged care are covered by that award.

141. The *Fair Work Act* provides avenues to make application to lift award wages such as work value reviews, equal remuneration cases and arbitration, however, these are time consuming- taking many years in most cases, often difficult to access, costly and do not have guaranteed outcomes.

Communication barriers

142. There are a number of factors in relation to communication that serve as impediments to achieving improvements through enterprise bargaining. These include the factors described above for casual and part-time workers, particularly those on night or weekend shifts, who are not available for face-to-face meetings that are important for collective organisation.

143. The percentage of workers from culturally and linguistically diverse (CALD) backgrounds in aged care raises language as a barrier to effective bargaining. It is rare for employers to translate bargaining information into languages other than English.

144. Access to technology is also an issue. Many employees will not have access to a computer at work or at home and are therefore unlikely to have their own work email address. This makes organising to take industrial action and to communicate about agreement negotiations difficult.

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[53] Equal Remuneration Case [2012] FWAFB 1000

Professional commitment to residents or care recipients and industrial barriers

145. Nurses and care workers are committed to the care of residents and care recipients. There is a strong cultural reluctance to take any action that may be seen to have a negative impact on residents.

146. Reluctance to bargain for enterprise agreements can also be influenced by employees' relationship with management. This is particularly the case in RACF's that operate on a small family business model where employees may have a strong sense of loyalty to the business and personal relationships with management.

147. In addition, nurses are required under the *Health Practitioner Regulation National Law Act 2009* to meet professional standards of care. Where staffing levels are already at a minimum, the capacity to take industrial action without impacting care is severely limited.

148. Employers prevail on workers' commitment to the people for whom they care. It is a common experience for employees to be informed that if they reject a proposed enterprise agreement, the provider will face financial hardship and be forced to close. Employees feel compelled to accept low wage increases for fear of losing jobs or facilities becoming unviable.

149. In the *ANMF National Aged Care Survey 2019*, members told us:

> *"The volume of work is overwhelming and add to that the expectations of Residents and their families and what they expect you to do straightaway. There are not enough hours in the day, we are constantly told there is no more money for extra staff and the company is in dire financial straights if we do not keep to the set budget. We rely on ACFI funding to pay staff wages and the hours have recently been cut which puts more pressure on the staff left as we have to make up the shortfall. Is it ok to go to work everyday and feel that the only way forward is to quit and go elsewhere, the only thing that stops me is that we are one of the good places. I have lost count of the thousands of hours I have given of my own time to make sure that residents care is the best I can give. I know literally that I have made a difference or averted a crisis but it's tough. Aged care is the toughest job I have ever had and unless you have worked at the coal face you will never understand."*
>
> *"Low wages with high expectations to provide clinical nursing care to our most vulnerable with the minimum of staffing each shift. We are told we have to provide 5 star service on a 1-star budget! I am still working in the industry because I genuinely care for those in my care and want to make their lives as happy and comfortable as I can."*

150. The capacity to take industrial action to pursue claims is further limited by industrial laws that provide that any action that threatens the health and safety of the community can be ordered to cease. For instance the Fair Work Commission must make an order suspending or terminating protected industrial action for a proposed enterprise agreement if it is 'satisfied that the protected industrial action has threatened, is threatening or would threaten: to endanger the life, the personal safety or health, or the welfare, of the population or part of it'. [54]

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[54] Fair Work Act 2009 s424

Provider shortcomings

151. Employer expertise in bargaining is mixed and not all providers engage industry organisations to represent them in bargaining. Lack of expertise can contribute to slow and difficult bargaining and delay in the agreement approval process.

152. Agreement approval data collected by the Fair Work Commission shows that in 2018, there were 168 applications under s185 of the *Fair Work Act* to approve single enterprise agreements finalised in the aged care industry. Of these, less than 5% were able to be approved without an undertaking.[55] This of itself is a disincentive to bargaining.

153. Providers rely in large part on Government funding to meet wage costs. However, neither the Government nor any funding authority representative is present at the bargaining table. This gives providers a 'cloak' to argue at the table that the funds they have available for wages is beyond their control or subject to pre-determined limits.

154. The lack of transparency and accountability with respect to funding of aged care and how those funds are expended by providers is a serious problem with respect to bargaining outcomes and more broadly.

Industrial strength of the workforce

155. Nurses in the public hospital sector are highly unionised and accustomed to the industrial process of collective bargaining and associated industrial action. Public sector employees are employed by one large employer and there is strength in numbers in bargaining.

156. The same is not the case for private for profit and not-for-profit aged care providers. For the reasons outlined above, union density in aged care is low and this reduces bargaining power. The predominance of care workers in aged care when compared to RNs and ENs is also a factor. Nurses have a strong industrial history and are likely in their careers to have experienced the benefits of collective activity. Care workers are more likely to have come from backgrounds that are not as well unionised and to be in insecure work. The impact is that where RNs and ENs are in the minority in a workplace, such as in many RACFs, their industrial capacity is reduced.

ANMF's efforts to combat the problems in bargaining outcomes in aged care

157. The ANMF's efforts to address these problems over a number of years include advocacy before federal and state industrial tribunals; where possible, industrial campaigns to support the bargaining process; submissions to Government reviews, inquiries and pre-budget submissions and broader political and community campaigns in response to widespread concern about the quality of care and workforce issues. The ANMF has consistently argued for wage parity with equivalent classifications in the public sector with a mechanism and dedicated funding to achieve this.

158. While employers have long maintained lack of funding is the problem, several Government initiatives to close the wages gap have not been passed on to nurses and

[55]Fair Work Commission, Agreement User Group-Common issues in agreement making, 8 March 2019

carers in the form of higher wages. In the 2002/2003 Federal budget, for example, $211.1 million was provided over 4 years to close the wages gap. Despite $110 million being dispersed over the next two years the wages gap doubled.

159. In the 2004/2005 Federal budget, $877.8 million over 4 years was allocated to assist aged care providers to pay "competitive wages". While some conditions were attached, providers were not required to direct the additional funding into higher wages. Again there was no impact on reducing the wages gap.

160. In 2010 the Government allocated $132 million to an aged care sector workforce package, but none of this money was used to close the wages gap.

161. As recently as February 2019, the Federal Government allocated an addition $320 million to residential aged care providers. This money was provided without any requirement to improve wages or staffing numbers.

Workforce supplement

162. In 2013, the *Living Longer Living Better* aged care reforms provided up to 1.2 billion dollars to the residential and home care sectors to address workforce pressures through two programs: an Aged Care Workforce Compact and Supplement (the workforce supplement) and an Aged Care Workforce Development Plan. They were targeted at assisting providers to build the capacity of the workforce by increasing wages, improving conditions, and providing better training and career opportunities. The workforce supplement, specifically, was a measure designed to assist the sector to attract and retain skilled staff and was funded to enable employers to offer more competitive wages.

163. The aims of the workforce supplement were to improve the sector's capacity to attract and retain a skilled and productive workforce and to provide funding to assist aged care providers deliver fair and competitive wages. Payment of the workforce supplement was linked to enterprise agreements, providing a transparent mechanism to ensure the additional funding met policy objectives – to improve wages and conditions of aged care workers.

Workforce supplement payments and criteria:

164. Eligible providers would receive additional funding based on a percentage of the basic daily subsidy amount as follows:

1% - 2013-14; 2% - 2014-15; 3% - 2015-16 and 3.5% - 2016-17.

165. Eligibility for additional funding:

In order to be eligible for additional funding, employers were required to undertake to either negotiate new enterprise agreements or vary existing enterprise agreements that included terms that gave effect to the following:

- At least a 1% additional wage increase on top of employer funded increases in each of 2013, 2014 and 2015 and a 0.5 increase in 2016;

- In addition, employers provide an annual employer-funded increase of at least 2.75% per annum or the Fair Work annual review increase, whichever is the higher;

- Agreement rates for AINs/PCWs and support staff be at least 3% above the Aged Care Award and agreement rates for ENs and RNs at least 8.5% and 12.65% above the Nurses Award respectively. This could be phased in over 3 years;

- Other workforce commitments to training and education, career structure and processes to support career development and workforce planning.

166. Providers with less than 50 places did not have to have an enterprise agreement but were required to meet the same terms and conditions per an undertaking with the Department of Health and Ageing.

167. The workforce supplement was introduced via the *Aged Care (Residential Care Subsidy Workforce Supplement Amount) Determination 2013* in June 2013. Following the federal election in September 2013, the Determination was repealed on 12 December 2013. This resulted in the entire program folding the 1.2 billion workforce supplement into ACFI via a one off 2.4% increase into the basic subsidy and the funds no longer being linked to improving wages and conditions for aged care staff.

168. The workforce supplement was the first time government funding to improve the wages of the aged care workforce was guaranteed to be passed on to staff. However, the incoming Government's shift in policy saw the funding allocated to the workforce supplement simply reabsorbed into general funding for providers with no tangible improvement for workers' wages.

Examples of cases run by the ANMF in Federal and State industrial tribunals

169. The following section provides a brief overview of specific examples of the ANMF's efforts to address the wages gap in the aged care sector.

170. 1999/2000: An application to the then Australian Industrial Relations Commission (AIRC) to make an Award covering nurses in aged care in Victoria following a successful application by the ANMF to terminate the bargaining periods in relation to approximately 356 aged care employers. The AIRC awarded a 15% increase, phased in over three years from 2000 to 2002 primarily citing the need to address recruitment and retention issues due to higher rates of pay in other sectors, particularly the public sector.

171. The ANMF made a similar application in the Northern Territory following unsuccessful attempts to bargain with aged care employers resulting in a similar outcome of 15% phased in over 3 years.

172. In 2005 the ANMF made an application to insert a new classification structure and wage rates for *Assistants in Nursing (Aged Care) in the Nurses Private Employment (ACT) Award 2002* resulting in recognition of the Certificate III qualification and increases for all AIN levels in line with the rate in the Queensland State Award (see below).

173. Similarly, in state jurisdictions, the ANMF has successfully sought improvements to aged care nursing classification structures and rates of pay on work value grounds. For example, in 2002, the Queensland Industrial Relations Commission inserted a new classification structure for AINs, ENs and a revised structure for RNs (*Nurses' Aged Care Award State*).

174. Following proceedings in the New South Wales Industrial Relations Commission commencing in 2003 and concluding in 2005, increases in rates of pay for all nursing classifications totalling 23% were awarded on "special case" and work value grounds. (The first two increases of 6% and 5% were by consent; the Commission awarded another two increases of 6% effective in March 2005 and 2006). (Nursing Homes &c., Nurses' (State) Award 2003).

Award Review process:

175. Improvements achieved in NSW and Qld State Awards were lost in the Award Modernisation process where over 100 Federal and State nursing awards were consolidated into a new occupational award for nurses and midwives - the Nurses Award 2010. This process required the Commission to use the relevant principal federal award as the starting point for drafting modern awards. As a result, gains made in the NSW and Qld State jurisdictions were not adopted and were phased out in the transitional provisions included in all modern awards.

Linking funding to wage outcomes

176. The above examples, in particular the lost opportunity to improve wages in aged care through the workforce supplement, illustrate that it is essential for providers to be held accountable for the funding they receive. Funding must be allocated and acquitted in a transparent manner and must be tied to the provision of care. The ANMF will deal with this issue in detail in a future submission.

PROBLEMS CONFRONTING AGED CARE WORKERS

Inadequate staffing levels and workload stress

177. Through the National Aged Care Survey 2019 members told the ANMF of the difficulties they face working in aged care. The concerns voiced by members are predominantly attributable to a lack of adequate staffing levels and skills mix.

178. ANMF members report that they feel stressed, overworked, undervalued and 'treated as numbers'. They also report that on many occasions the care needs of their clients are missed because they don't have time to provide adequate care. In addition to the impact on quality of care, members' own health and safety is put at risk when staffing levels and skills mix are inadequate.

179. The ANMF submission 'Aged Care in the Home'[56] sets out members' concerns related to working in home and community aged care. The themes of experiencing workload stress, lack of staff and support, unreasonable demands, lack of appropriately skilled workforce and lack of time to care are elaborated upon in that submission.[57]

180. The ANMF submission 'Aspects of Care in Residential, Home, Flexible Aged Care Programs, Rural and Regional Issues for Service Delivery of Aged Care, And Quality of Life for People

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[56] ANM.0002.0001.0001
[57] Ibid p0011-0014

Receiving Aged Care'[58] while focussing on quality of care, also highlights the stress and concern members experience in the workplace.

181. Members responses to the National Survey summarise those concerns:

"I do not know of any other work where there is such high responsibilities and stress to staff. There is a huge physical work load and documentation workload, emotional demands from residents, their families, expectations are beyond acceptable, the Royal commission needs to focus on how to gain and retain good staff, who love and care for their residents and to value their contribution, not make life harder, having to prove we doit all perfectly. People are getting sicker from the stresses imposed, when the work place should be a happy, caring environment that fulfils residents' needs, values staff and is a joy to work at."

"I love my work. It's my passion, but to not be able to provide the best care possible to these vulnerable people who deserve this breaks my heart. My facility is amazing, and we do a great job but can only do this in a rushed, stressful environment due to staffing levels. Fix this and more nurses will want to join the aged care sector. A pay rise to meet the same rate as hospital-based nurses would also attract. We do this job not for the pay but for the caring empathetic people we are and our love of the elderly. Basic needs cannot be met effectively, and this has to change! ..."

Role Substitution/Scope Creep

182. A growing body of national and international research and evidence clearly demonstrates that inadequate levels of qualified nursing staff lead to an increase in negative outcomes for those in their care, which results in increased costs. In the acute setting, the implementation of safe mandated minimum staffing has been shown to prevent adverse incidents and outcomes, reduce mortality and prevent readmissions thereby cutting health care costs. It is widely agreed that the same improvements could be achieved in the aged care sector.

183. However, rather than look to the benefits of better utilisation of qualified nurses, there is increasing discussion in the aged care sector about educational requirements for care workers, particularly around expansion of their roles and potential increases to the scope of activities they currently perform. Many of these proposed activities sit well within the existing practice of enrolled nurses and registered nurses. Not only would it be wasteful and unnecessary to attempt to expand the activities of care workers when suitable other workers already exist, it would be profoundly unsafe.

184. As referred to in **paragraph 17 above**, it is apparent over the last decade, that there is an ongoing reduction in the percentage of the aged care workforce made up of RNs and ENs. At the same time, the number of care workers is increasingly making up a greater percentage of the workforce.

185. The ANMF acknowledges the work and skills of care workers and that they are an essential part of the workforce. However, the ANMF is opposed to the replacement of registered nurses and enrolled nurses with care workers where the work requires the skills and knowledge of either a registered nurse or an enrolled nurse.

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[58] ANM.0005.0001.0001

186. Registered nurses are responsible and accountable for making decisions about who is the most appropriate person to perform an activity that is in the nursing plan of care. The registered nurse is required to complete a comprehensive assessment of the person receiving the care and identify if the nurse or non-nurse being delegated the care is competent and safe to do so. Registered nurses are also then required to provide adequate supervision.

187. The current environment in aged care is such that nurses, particularly registered nurses, frequently feel compromised in their efforts to meet their professional and legal obligations as set out by their regulatory authority. The environment is frequently incongruent with nurses' regulatory requirements and registered nurses are understandably deeply frustrated.

188. Inadequate staffing levels and workloads compounded by unreasonable (and even potentially unlawful) requests from employers to direct care staff to undertake tasks for which they may not possess the skills, leave many nurses feeling vulnerable and at risk of personal regulatory consequences.

189. The ANMF's concern therefore, is that by reducing the number of nurses in the aged care workforce, resident and consumer care is being compromised. Member responses to the ANMF National Survey illustrate the problem:

Question: What are the issues you are most concerned about?

"Unqualified staff giving medications - only EEN or RN should be giving medications. Management twist or misinterpret laws or regulations involved for medication management and train AINs or PCWs to give medications out to all residents in Aged Care Facilities."

"The ratio of RN to EN is not high enough. ENs are making decisions and liaising with Doctors & family over matters for which they are not educationally prepared."

"Care Workers should not be allowed to give medication in Aged Care or Disability - that is what EN's are for."

"We now have to cook meals, wash dishes, clean rooms and other areas, do the residents laundry entertain them, as well as personal care, pressure area care, and continence care, and dressings, deal with behaviours, and safely administer medications."

"Supervision/Reporting lines are not correct e.g. RNs are having to report to EN Clinical managers and PCAs are overseeing the completion of nursing assessments for ACFI Funding purposes."

"Upper management counted as staff on the floor. It's not true; they will not help on the floor."

"The number of unqualified carers being given the ability to give medications. Whilst ENs and RNs have to pay for this privilege yearly and do Continued Education to maintain registration, it's scary that this is allowed to happen."

"Medication Management-Personal Care Workers work beyond their scope of practice, dangerous life-threatening medications i.e. Schedule 8 drugs, Anticoagulant Medications and Psychotropic Medications in Dose administration Aids given out by PCWs. Who performs invasive procedures like Insulin and Enema administration when no RN?"

190. The ANMF is particularly concerned about the erosion of the role of ENs. Both the

statistics about workforce proportion and the anecdotal evidence supports the argument that providers are electing to engage less qualified staff to perform work that should be done by qualified nurses. It is hard not to view this trend as an effort in cost cutting by providers that comes at the expense of quality of care. As one member told us in the 2019 ANMF National Aged Care Survey:

> *"Staff hours and numbers were cut so much we were not able to take our breaks and always left work late* [residential aged care facility] *and still we were struggling to attend to the cares of all the high care residents. Not being able to answer a buzzer quick enough resulted in residents soiling themselves and losing their dignity OR trying on their own without assistance and falling and breaking bones. It broke my heart and I had to move to another nursing home."*

191. At the same time, RNs are being increasingly utilised to perform administrative and management functions with less direct resident or consumer care and RN numbers being reduced. The following responses from the ANMF National Survey illustrate the concerns:

Question: Do you think the ratio of registered nurses to other care staff in your facility are adequate?

"Many RN duties have been removed from direct patient contact which impairs residents' health assessment and timely and adequate treatment."

"Often on an afternoon shift a EN will be designated to be in charge of the whole facility, with access to an on-call RN. Even when the EN objects to this situation they are not listened to."

"Not enough care staff for resident needs. Push by management to reduce RN's although high care residents who need RN's."

"When the role of the RN is purely clinical then yes. However the RN is frequently required to attend to duties which are outside the scope of clinical practice. This leaves Care staff to frequently work without adequate supervision. Also RN's are regularly replaced by EN's with the EN expected to perform the duties of a RN. This is often as a result of not enough RN's on staff. Management claim that there are very few who are suitable looking for employment for many reasons."

"I work in the facility of 120 residents with 2 RN on the floor which not safe at all to provide care. Pc's made to administer medications to residents because RN is too busy doing administrative workload."

"Care staff are doing medication rounds which can sometimes include wound management, etc. They work under instruction from an RN or EN but are independent whilst doing the round. I believe they are not adequately trained or skilled to be handling Medications and that job should be done by someone who is skilled in that area. We are carers not nurses. The longer we allow this practice to continue the more of a "norm" it will become. It is a money-making exercise that is not in the best interest of the community it serves."

"I think this is adequate only because a lot of facilities allow enrolled nurses or carers to do registered nurse jobs."

"I have a fairly high level of RN compared to other sites but I believe any lower would be dangerous. I am often pout under pressure to reduce the number of RN and told that if I reduced the RN numbers I could have more care staff. My counter argument is why would I replace clinical

expertise with a Cert III? And if I did then the difference would be very obvious in the Clinical Indicators. I must admit I am running out of energy to keep having this argument and to constantly justify why I have the number of RN on the floor that have. They are currently working at 1 RN :40 Residents in AM, 1 RN:64 Residents in the PM and 1 for 128 at night. They are also supported with EN with 3 EN per AM & PM shift. Any slimmer would be very substandard and extremely dangerous."

"Using EEN's to replace RN's and get away with it."

"registered nurses extremely overworked and no one to cover sick leave. Have to use ENs and PCAs to fill gaps and also seriously over work RNs."

"Unqualified staff having to do RN work such as meds in dementia and sometimes high care unit."

192. The Korn Ferry report found *'Overall, there is a significant scope creep in nursing roles- they are treated as a 'jack of all trades'*. This creates significant issues in role clarity for nurses leading to 'burnout' and ultimately their exit from the aged care industry.[59]

193. The effects of inappropriate role substitution or 'scope creep' include:

- Increased risk of medication error
- Increased risk of missed care
- Decrease in the delivery of safe and quality care
- Greater delay in identifying health concerns of residents and consumers
- More unnecessary hospital admissions
- Unreasonable workload pressure and stress
- Job dissatisfaction
- Undervaluing the profession.

Workplace violence and aggression

194. Experiencing violence and aggression from residents and their family members is disturbingly common for workers in aged care.

195. In 2018, the NSW Nurses & Midwives' Association collaborated with Dr Jacqui Pich of the University of Technology, Sydney to conduct an extensive survey of nurses and midwives in NSW looking at their exposure to patient related violence and aggression. The survey asked about all forms of violence, including sexual harassment as experienced by nurses and midwives from patients, relatives and visitors to health services. It did not look at violence between colleagues at work. The findings formed the report 'Violence *in Nursing and Midwifery in NSW: Study Report* (the Pich report)[60].

196. The survey attracted responses from 3,416 participants, working in all areas of nursing and midwifery across the public sector (78%), private sector (16%) and not for profits (7%). Reflective of gender representation in the industry, 87% of respondents were women. 16% of respondents identified as working in aged care. The findings referred to

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[59] Korn Ferry|Hay Group, 38

[60] Jacqui Pich, Christopher Oldmeadow and Matthew Clapham 'Violence in Nursing and Midwifery in NSW:Study Report' (The Pich Report)

below are overall findings, but indicate that experiencing violence in the workplace is a significant issue in aged care.

197. Of the total number of participants surveyed, 47% reported experiencing an episode of violence in the previous week and 80% in the 6 months prior to completing the survey. Of the respondents in aged care 79% had experienced violence in the 6 months prior to completing the survey.[61]

198. The report looked at the type of violence experienced in the previous 6 months. Verbal or non-physical violence was the most common type of violence reported, with 76% of participants experiencing an episode. Of those participants who had experienced verbal or non-physical violence, 25% had experienced sexually inappropriate behaviour.

199. Nearly, 25% of participants reported physical abuse/violence in the previous 6 months. Of those participants 13% experienced inappropriate sexual conduct and 2% - or 35 individuals- had experienced sexual assault.

Impact of violence

200. The Pich report examines the consequences of episodes of violence.

201. 28% of participants reported they had suffered a physical or psychological injury as a result of an episode of violence. Nearly a third of those sought medical attention and over a third took time off work ranging from the remainder of a shift to over a year.

202. Some participants elaborated by saying they ended up resigning, were forced into retirement or took random days off when too distressed to work. The impact of violence can be highly detrimental to the working lives of nurses and midwives in terms of time away from work. Absence from work also impacts on colleagues, management of services and care of patients and health care recipients.

203. The Pich report also identifies the emotional consequences of experiencing violence at work. These can range from long term psychological harm to feelings of unhappiness, powerlessness, fear, anxiety, shame and guilt.

204. This extract from the Pich report shows the range of detrimental effects that can be experienced:

4.4.1 Emotional response

Participants reported a range of ongoing emotional responses following an episode of violence, some of which indicated negative coping strategies, for example "increase in use of alcohol or other substances/medications". A number of the responses were long-term in nature, including those linked to Post Traumatic Stress Disorder (PTSD), for example "weight loss/gain", "nightmares and flashbacks" and "altered sleep patterns". PTSD itself was selected as a response by 8% of participants. In addition some responses impacted

[61]The Pich Report,35

the nursing practice of participants, for example "withdrawal from people/situations" and "fear/anxiety re future episodes" (Table 18). [62]

205. The report identifies that in addition to the impact on the individual there is a clinically adverse outcome for health care recipients as well. Participants reported a withdrawal not only from an offending individual but were more likely to experience a lack of empathy for patients generally. A loss of ability to empathise and interact with patients is detrimental to the overall ability to provide care.

206. With reference to other studies, Dr Pich concludes that nurse 'burn out' leads to a lack of joy in providing care and spending less time with patients whom they perceive as abusive. '*Thus the negative effects of patient related violence extend to the workplace and can lead to difficulties with the recruitment and retention of nurses, decreased productivity and efficiency, increased absenteeism and fewer resources for nurses.*'[63] There is a cost flow on to the recruitment and retention of nurses and workers compensation claims.

207. Participants were asked to rank a number of staffing issues from highest to lowest in terms of the risk of potential violence they perceived them to have. The responses related to the numbers of staff, the experience and skill of staff and workload. [64]

Table 30: Staffing-specific factors (ranked)

Rank	**Factor** (n = 1895)
1	Inadequate staffing
2	Workload and time management
3	Inadequate skills mix
4	Lack of staff skills to manage episodes of violence
5	Nursing practice and attitudes of individual nurses
6	Inadequate communication with patients and relatives, friends or visitors e.g. about waiting times
7	Lack of training e.g. in de-escalation techniques, restraint, dementia care
8	Professional communication issues e.g. handover/documentation

208. The Pich report noted that the negative effects of patient-related violence can lead to difficulties with recruitment and retention, decreased productivity and increased absenteeism and fewer resources for nurses[65]. It identifies the cultural problem of assuming experiencing violence is part of the job and therefore is not reported nor acted upon.[66]

209. These issues are highlighted in the following member response to the 2019 ANMF National survey:

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[62] The Pich Report 49-50
[63] Ibid 71
[64] Ibid 59
[6565] Ibid 71
[66] Ibid 72

"Despite the negative images which broadcast on media, I do get to know the people who are absolutely dedicated to deliver the best possible quality care to the elderly. But when we get misunderstood, we get abused too (and we are asked not to make a big fuss so we all tend to put up with it), sometimes by the families and sometimes the violence comes from residents themselves. These days, aged care facilities accept more residents with mental illnesses, ranged moderate to severe. Dementia is not an exemption. They can be quite full on, requires lot of 1:1 to de-escalate their behaviours. However, we never get enough support. The recommendations from the offsite mental health services never consider the levels of staffing and resources, most of the suggestions are general but unrealistic. Imagine if you under pressure of everything, over time, you will lose your compassion... till the day you can handle no more, then you will leave the industry."

210. Improved staffing levels and skills mix will reduce the risk of violence in aged care workplaces and consequently reduce recruitment and retention difficulties.

PERCEPTIONS OF AGED CARE AND CULTURAL VIEWS OF ELDERLY PEOPLE

211. The Aged Care Workforce Taskforce examined how the community and the industry itself views aged care.[67] Indeed, as Professor John Pollaers poignantly remarked:

"A matter of care is for all Australians, because the way we care for our aging is a reflection of who we are as a nation. How we care says who we are."[68]

212. The Report of the Taskforce, *A Matter of Care*, outlines how the aged care sector has become increasingly aligned with a consumer-centric style of market. Consumer expectations and preferences for aged care have changed (and will continue to change) along with broader beliefs about ageing itself. People desire increased choice and autonomy and have expectations regarding safe, consistent, and high-quality care. Person-centred care is also a strong priority for many.

213. The many reports of quality and safety issues in the aged care sector, both prior to and heard by the present Commission have led many people to regard the aged care industry, its providers and its workforce, to be failing those who engage with aged care services as either care recipients or family and loved ones of those in aged care. These are not isolated cases, and while all instances have involved individual staff and providers, the sheer number and distribution of concerns and complaints regarding the safety, appropriateness, and quality of aged care in Australia points to an ongoing systemic crisis.

214. Working in aged care has been described as being negatively perceived. An analysis of the perceptions of people who work in aged care including care managers, nurses, carers, domestic staff, and speech pathologists revealed four key themes that were common across all groups;[69] working in RACFs is personally rewarding and challenging;

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[67] Aged Care Workforce Taskforce. 2018. A matter of care: Australia's Aged Care Workforce Strategy - Report of the Aged Care Workforce Strategy Taskforce [Internet]. Commonwealth of Australia, Department of Health. Canberra, ACT. Available online: https://agedcare.health.gov.au/aged-care-workforce-strategy-resources

[68] Ibid.

[69] Bennett MK, Ward EC, Scarinci NA, Waite MC. 2015. Service providers' perceptions of working in residential aged care: a qualitative cross-sectional analysis. *Aging and Society*. 35(9):1989-2010. Available online: https://www.cambridge.org/core/journals/ageing-and-society/article/service-providers-perceptions-of-

relationships and philosophies of care directly impact service provision; staff morale and resident quality of life; a perceived lack of service-specific education and professional support impacts service provision, and; service provision in RACFs should be seen as a specialist area. The authors called for aged care providers to work collaboratively with staff to address these issues and continue to advocate for the recognition of RACFs as a specialist service area.

215. The negative perceptions around working in aged care are not new nor are they an exclusively Australian phenomenon.[70,71,72,73,74] Indeed, aged care nursing has suffered from a poor image due to perceptions regarding lower status in comparison to more technical fast-paced acute care environments and concerns regarding funding, staff levels, and quality of care.[75, 76]

216. Nurse participants in a study examining the experiences of working in aged care revealed that nurses felt concerned about de-skilling, role clarity and accountability and felt that aged care nursing is being devalued and is emotionally and physically draining. These feelings are amplified by challenges related to poor staff-skill mix, high staff turnover, poor retention and instability of key roles as well as the number of junior and inexperienced staff needing support and supervision.[77]

217. While perceptions regarding working in aged care may not be positive – which appears to largely be related to awareness of the systemic challenges and problems that appear to be prevalent in many countries' aged care sectors, undergraduate nurses themselves have largely positive attitudes, perspectives, and perceptions regarding older people and working with older people.[78] These attitudes however, do not appear to be fixed, as another study found that working in aged care was the least desirable career choice for graduating nurses which appeared to be driven by socialising factors within the education process, negative clinical experiences, and ageist biases within the broader community.[79]

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working-in-residential-aged-care-a-qualitative-crosssectional-analysis/124E555142EC1849B8ADCEA7A9791268

[70] Carryer J, Hansen CO, Blakey JA. 2010. Experiences of nursing in older care facilities in New Zealand. *Australian Health Review*, 34(1):11–17.

[71] DeForge R, van Wyk P, Hall J, Salmoni A. 2011. Afraid to care; unable to care: A critical ethnography within a long-term care home. *Journal of Aging Studies*, *25*(4), 415–426. doi:http://dx.doi.org.access.library.unisa.edu.au/10.1016/j.jaging.2011.04.001

[72] Harrington C, et al. 2012. Nursing home staffing standards and staffing levels in six countries. *Journal of Nursing Scholarship*, 44(1): 88–98.

[73] Kaine, S., & Ravenswood, K. 2014. Working in residential aged care: A Trans-Tasman comparison. *New Zealand Journal of Employment Relations*, 38(2):33–46.

[74] Spilsbury K, Hewitt C, Stirk L, Bowman C. 2011. The relationship between nurse staffing and quality of care in nursing homes: A systematic review. *International Journal of Nursing Studies*, 48(6):732–750.

[75] Fussell B, McInerney F, Patterson E. 2009. Experiences of graduate registered nurses in aged care: A case study. *Contemporary Nurse*, 33(2): 210–223.

[76] Baldwin, R. 2013. Building a resilient and sustainable workforce in aged care (Editorial). *Contemporary Nurse*, 45(1):7–9.

[77] Davis J, Morgans A, Birks M, Browning C. 2016. The rhetoric and reality of nursing in aged care: views from the inside. *Contemporary Nurse.* 52(2-3):191-203.

[78] Neville C, Dickie R. 2014. The evaluation of undergraduate nurses' attitudes, perspectives and perceptions toward older people. *Nurse Education Today.* 34(7):1074-1079.

[79] Stevens JA. 2011. Student nurses' career preferences for working with older people: A replicated longitudinal survey. *International Journal of Nursing Studies.* 48(8):944-951.

218. The Aged Care Workforce Taskforce noted that in Australia, there is a prevalent and negative societal attitude towards ageing, which is viewed as a problem and a burden. Death and dying are also negatively perceived. The Taskforce recommended that a social change campaign must be deployed as a matter or priority to reframe caring and to promote the workforce.[80]

219. Based upon the Taskforce's workshops and community consultations, perceptions that ageing and caring for the aged is a burden are described to be built upon:

- past experiences of families and carers;
- highly negative portrayals of ageing and aged care in the media and public discourse;
- lack of understanding of the aged care system and available supports, and;
- inherent fears and frustrations with aging and death.[81]

220. The Taskforce linked these negative perceptions with partly why the aged care sector struggles to attract new workers and why current workers feel undervalued and even persecuted by the community.

221. Ageism can be described to manifest in multiple ways; negative attitudes towards older people, old-aged and the ageing process; discrimination or unfair treatment of older people; and, the implementation of policies or practices that reinforce or perpetuate negative stereotypes of older people.[82] As with other forms of discrimination (e.g. sexism, racism, homophobia) ageism can have significant detrimental impacts upon peoples' health and wellbeing. In a broad sense, widespread ageism may perpetuate a culture and society where older people are not valued or treated fairly.[83] Where negative stereotypes of older people are common and where the care of older people is not typically considered important or meaningful. In a narrower sense, there is evidence that shows that the experience of ageism on the individual is also powerful and detrimental, especially upon mental health.[84]

222. Negative perceptions of ageing, death, and dying may also be held by older people themselves and may also be related to poorer physical and mental outcomes.[85] A systematic review of 28 observational studies found that the way that older people (60 years and older) perceive ageing is related to their health and functioning across multiple domains; memory and cognitive performance, physical and physiological performance, medical conditions and outcomes, care-seeking, self-rated health, quality of life, and

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[80] Ibid [1]
[81] Ibid.
[82] Lyons A. et al. 2018. Experiences of ageism and the mental health of older adults. *Aging and Mental Health*. 22(11):1456-64. Available online: https://doi.org/10.1080/13607863.2017.1364347
[83] Horton S, Baker J, and Deakin JM. 2007. Stereotypes of Aging: Their Effects on the Health of Seniors in North American Society. *Educational Gerontology*. 33(12):1021-35. Available online: https://www.tandfonline.com/doi/full/10.1080/03601270701700235?src=recsys
[84] Ibid. [6]
[85] Wurm S, Benyamini Y. 2014. Optimism buffers the detrimental effect of negative self-perceptions of ageing on physical and mental health. *Psychology and Health.* 29(7):832-48. Available online: https://doi.org/10.1080/08870446.2014.891737

death.[86] Across each domain, more negative ageing perceptions were related to poorer health and functioning. The comprehensive account of the relationship between older adults' aging and their health appeared to indicate the possibility of a bi-directional relationship between perceptions of ageing and health where older peoples' negative attitudes towards ageing could predict or influence their health and be explained by their experiences of health and wellbeing across the above domains. Factors that appeared to be related to negative perceptions of ageing among older people included:

- Perceptions that one's own health was poorer than others
- Attributions of illness to old age
- Lower quality of life (particularly among people with dementia)
- Better recall memory performance
- Poor vision
- Difficulties with activities of daily life (including instrumental activities)
- Greater dependency on assistance
- Decreased physical functioning
- Presence of multiple co-morbid conditions (but not a single chronic condition)
- Tremors/shaking (not associated with disease)
- Dementia (in terms of psychosocial loss)
- Greater number of medical appointments
- Greater number of days off work due to illness
- Less regular exercise and physical activity
- Poorer medication adherence
- Poorer diet, sleep and rest
- Reduced health care seeking
- Risk of shorted survival (greater mortality risk

223. Factors related to positive perceptions of ageing among older people included:

- Better self-rated health
- Psychological wellbeing
- Higher health status
- Better quality of life (including among RACF residents)
- Better vision and hearing
- Physiological performance (ability to walk further)
- Less physical performance deterioration
- Less difficulty and need for assistance with activities of daily living
- Higher functional health status
- Slower rates of decline in activities of daily living
- Higher rates of exercise and physical activity
- Lower mortality risk

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[86] Warmouth K, Tarrant M, Abraham C, Lang IA. 2015. Older adults' perceptions of ageing and their health and functioning: a systematic review of observational studies. *Psychology, Health and Medicine.* 21(5):531-50. Available online: https://doi.org/10.1080/13548506.2015.1096946

224. Assessing the above factors that either increase and/or explain more negative attitudes towards ageing (and conversely reduce and/or explain these negative attitudes) provides a range of practical and actionable interventions that may be implemented with older people within and outside RACFs in order to improve health and wellbeing as well as their own attitudes towards the ageing experience.

EFFECTIVE RECRUITMENT AND RETENTION

225. Despite being a complex and specialised area, aged care continues to be regarded as something of a 'poor cousin' within the broader context of the health system in which the majority of nurses traditionally work. This is not just because of the poor wages and working conditions as outlined extensively above, or just as critically, because of the significant professional difficulties encountered by nurses and, increasingly, care workers working in the sector, but also because of the lack of adequate preparation for aged care work and professional career opportunities in the aged care sector.

Theoretical preparation

226. Aged care is a multifaceted specialty area that requires expertise, education, experience, and a significant suite of skills to effectively, efficiently, and safely deliver care to a cohort of the population that is particularly frail, vulnerable, and at high risk of complications from all aspects – pharmacological (higher incidence of side-effects and interactions), nurse-sensitive adverse events (for example, urinary tract infections, chest infection, pressure injuries), acute deterioration and general decline (from worsening chronic conditions and/or additional acute illnesses), and accidents (falls in particular).

227. We need to continue to prepare nurses of the future for this sector, through education and destigmatisation. The ANMF recommends that, as identified in our previous submissions, [87] aged care specific theory and practice in pre-registration programs for both registered and enrolled nurses, including dementia care and palliative care, could be improved. This would equip graduates better for work in the sector and enhance care delivery for people in aged care.

Clinical learning

228. Equally important as the inclusion of sufficient aged care specific theory in educational programs is ensuring quality clinical placements in aged care settings for students of degree and diploma programs. The ANMF's education submission, referenced earlier in this submission, examines the importance of quality clinical placements for nursing students and the key factors required to achieve this. When quality placements are provided, they effectively prepare students, as beginning or novice practitioners, for the workplace. However, we are frequently provided with feedback regarding the lack of quality of aged care placements.

229. One of the key issues is the lack of staff, particularly in residential aged care facilities. The staff is insufficient in number, and often skill, to provide adequate preceptorship to students. Too often, there are no nurses available to provide supervision and support, or to encourage and foster reflective practice. The environments, also frequently, are not

[87] ANM.0003.0001.0005 & ANM.0004.0001.0008-9.

conducive to learning and do not promote positive learning cultures. In addition, also too often, we hear from members that aged care placements tend to focus on foundational or basic care rather than allow students to appreciate the complex nature of the specialty.

230. Students who experience these negative conditions are unlikely to choose aged care as a specialty once they graduate.

231. In addition to their studies, students of nursing may gain employment in aged care prior to the completion of their degrees or diplomas. This may be one way of gaining early exposure to the sector. However, as with clinical placements, members report to us that if their experience is a negative one, they are very unlikely to seek permanent employment in the sector.

Transition to the workforce

232. Another important element in attracting and retaining nurses and care workers in the aged care workforce is ensuring effective transition from the educational environment into the workforce. When the features of effective transition, as outlined in the ANMF's education submission, are in place the new graduate is provided with the opportunity to consolidate their learning and establish themselves as a competent practitioner. There are however, few examples of where graduate transition is done well in the aged care sector.

233. Too often, members report that they are unsupported, there are few formal or structured programs to guide their transition and development as a new practitioner and they are frequently exposed to environments that are dangerously understaffed placing new graduates at unreasonable professional and personal risk. It is unlikely that many newly graduated nurses would choose to remain working in such environments.

Career progression

234. As identified earlier in this submission, there are limited opportunities for career progression and development for nurses in the aged care sector, particularly when compared to the public health sector but also when compared to the private acute sector. Some opportunities are available for progression to management and there may be some opportunities for progression into education, and clinical education. There are however, few opportunities for nurses to progress as clinical specialists or experts and very few career structures available in the sector to support this progression.

235. An exception is the potential for nurses to progress to a nurse practitioner (NP) role. In aged care settings, nurse practitioners have an important role in providing support and direction to registered nurses and enrolled nurses in the complex care needs and chronic disease management of residents such as diabetes, respiratory conditions, urinary conditions, and cardiac disease. More importantly they provide timely intervention to prevent unnecessary admission to tertiary health care facilities.

236. ANMF members have identified that having a NP within their residential facility has not only improved care through direct care delivery but also through the NP providing support and education for nurses and care workers. Members have further identified that the NP's presence can empower them to improve care delivery in facilities where clinical governance structures are lacking.

237. However, as above, opportunities for this progression are also limited. There are significant barriers for nurses wishing to become NPs, including lack of workplace support, education costs, and the lack of permanent job opportunities following formal endorsement as a nurse practitioner. These issues are examined in detail in the ANMF's education submission.

238. Investing in increasing the nurse practitioner workforce and enabling innovation in models of care, is key to meeting the projected demand arising from the substantially increased proportion of complex care for older people in both residential aged care and home care. In addition, the nurse practitioner workforce has the potential to deliver significant cost savings.

Why nurses choose to work in and stay in aged care

239. A small Canadian study was conducted to better understand the factors that attract registered nurses to gain employment and remain working in the aged care sector.[88] The study found that despite perceptions that working in aged care was an unattractive choice in comparison to working in a hospital, participant nurses appeared to often choose to work in aged care due to convenience. Organisational characteristics and environment including support for professional education and training, flexible working arrangements, as well as the caring relationship between staff and residents were significant factors regarding remaining in aged care.

240. While some participants described deciding to work in aged care due to difficulty finding employment in other sectors, others explained their specific interest in geriatric nursing and long-term care were major factors for selecting aged care as an employment area of choice. The authors recommended that marketing positive aspects of working in aged care, particularly opportunities regarding developing caring relationships with residents and their families, professional development opportunities, and job flexibility may improve the attraction and retention of registered nurses in the aged care sector.[89]

241. Similar positive factors regarding working in aged care as a registered nurse were also identified in another Swedish study of perceptions of working in RACFs.[90] The three key categories around nurses' experiences of working in aged care included establishing long-term relationships with residents and families, nursing beyond technical skills and utilising a broader and more complex skillset regarding the provision of holistic, person-centred care, and balancing independence with loneliness due to the relatively lower numbers of other registered nurses and higher ratios of clients.

242. In the Australian context, altruism appeared to be a primary motivator for deciding to work with older people and people with dementia.[91] A large Australian study with 3,983

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[88] Prentice D, Black M. 2007. Coming and staying: a qualitative exploration of Registered Nurses' experiences working in nursing homes. *International Journal of Older People Nursing.* 2(3):198-203.
[89] Ibid.
[90] Carlson E, Rämgård M, Bolmsjö I, Bengtsson M. 2013. Registered nurses' perceptions of their professional work in nursing homes and home-based care: A focus group study. *International Journal of Nursing Studies.* 51(5):761-767.
[91] Chenoweth L, Merlyn T, Jeon YH, Tait F, Duffield C. 2014. Attracting and retaining qualified nurses in aged and dementia care: Outcomes from an Australian study. *Journal of Nursing Management.* 22(2):234-247.

nurse participants identified and examined key issues and factors affecting retention of qualified nurses who care for older people and persons with dementia in Australian acute, subacute, community and residential health-care settings. The following emerged as key recommendations for improving the recruitment and retention of nurses in aged care and are focused upon bolstering decision-making among nurses and improving workplace focus and structures:

- Involve nurses in system change plans, implementation strategies and evaluation of change on patient outcomes.
- Consistently consult with nursing staff on policy, procedures and care practices.
- Allow nurses more autonomy to run their departments and nursing budgets.
- Enable nurses to employ their diagnostic and clinical skills and to make judgments about nursing care.
- Create formal avenues to acknowledge nursing expertise within teams.

- Create partnerships among different health settings to promote reciprocal nurse secondment to transfer necessary skills, expert knowledge and new ideas.
- Create innovative working environments that involve nurses in quality projects and research.
- Provide education and supervision in patient and person-centred care.
- Provide structured support and mentoring for new graduates employed in the organisation.
- Maintain appropriate numbers of qualified nurses at the bedside as direct-care providers, mentors and supervisors.
- Facilitate staff development in clinical and management areas for qualified nurses
- Support positive staff/resident interaction through the adaptation of existing resident documentation to facilitate the recording of strengths/abilities as opposed to deficits.
- Facilitate access to the Internet for educational purposes, information sharing and clinical assurance on current methods of best practice.

243. These features are all too often absent from Australia's aged care system.

Why nurses and care workers are leaving or considering leaving the aged care workforce

244. Retention of staff in aged care is a significant concern with respect to ensuring the aged care workforce's capacity and capability to provide high quality care and support and good quality of life for care recipients.

245. This submission identifies low wages, workload stress and violence and undervaluing of both the work and workforce in aged care as concerns for those working in aged care. Lack of support transitioning into the workforce and opportunities for career development are also issues of concern. The combined effects of inadequate staffing levels and skills mix all impact on the ability of those working in aged care to deliver the care they wish to offer both personally and professionally. This leads to 'burnout' and disillusionment in working in the aged care sector.

246. The ANMF conducted a short survey between 17-23 September 2019 asking members if they had left aged care altogether, changed employers or were thinking of leaving aged care or their current employer. Key outcomes of the survey and member responses are outlined in the section below. A more detailed analysis of the survey results will be provided to the Royal Commission at a later date.

ANMF Aged Care Survey – Have you left or are you thinking of leaving aged care?

247. Over 2000 responses were received, with approximately 41% of respondents working in private residential for profit facilities and 43.5% in not for profit private residential care.

248. Just over 1900 members responded to the question below. The answer tells us 40% (n= 775) of respondents have left their aged care employer or the aged care sector entirely. 771 members told us why they had left. **See tables A and B below.**

Table A

Q7 Have you left your aged care employer or the aged care sector entirely?

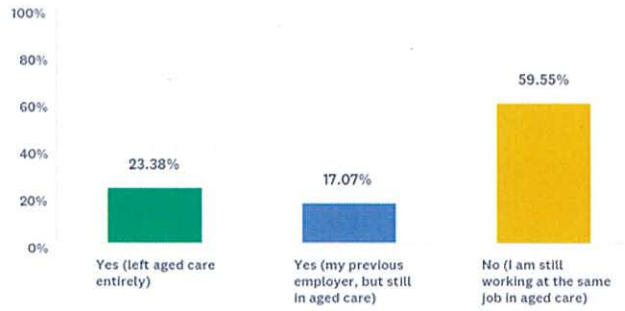
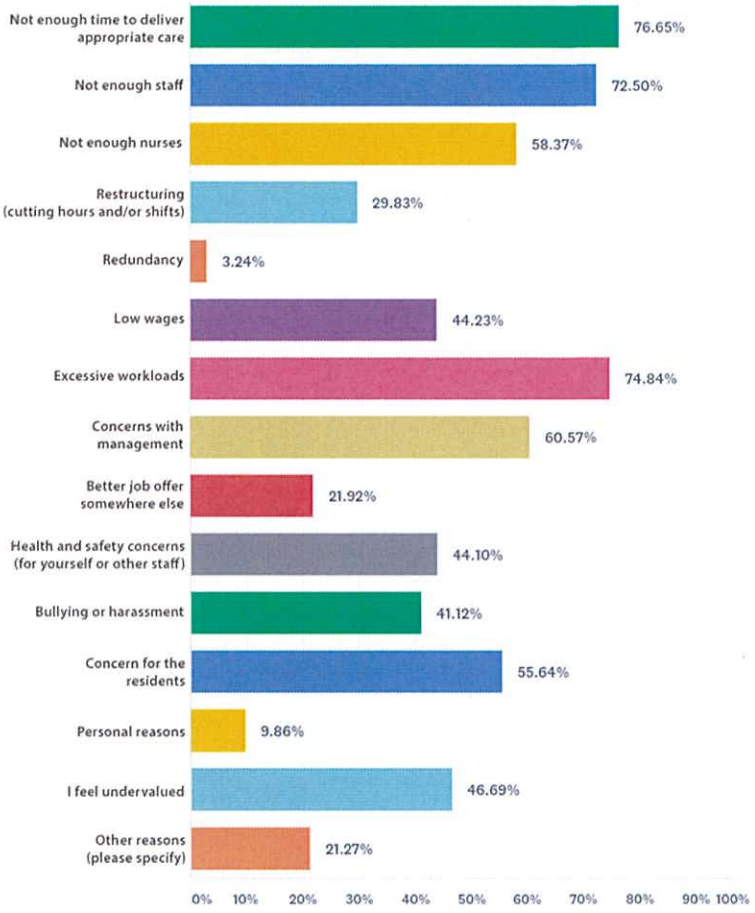


Table B

Q8 If you left a previous aged care employer or stopped working in aged care entirely, why did you leave? (you can select more than one)



249. For those respondents who had not left, 72.5% (n= 1,125) are considering leaving with nearly 50% of those considering leaving aged care altogether. 813 respondents responded as to the reasons they are considering leaving. See **tables C and D below**.

Table C

Q9 Are you considering leaving your employer or aged care entirely?

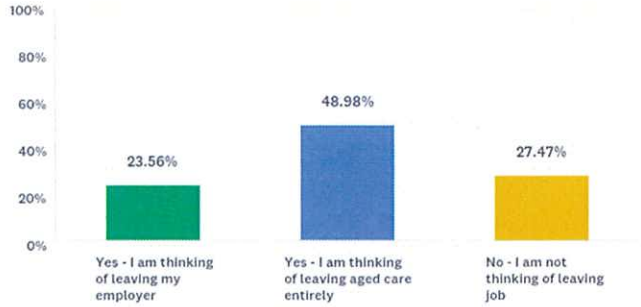
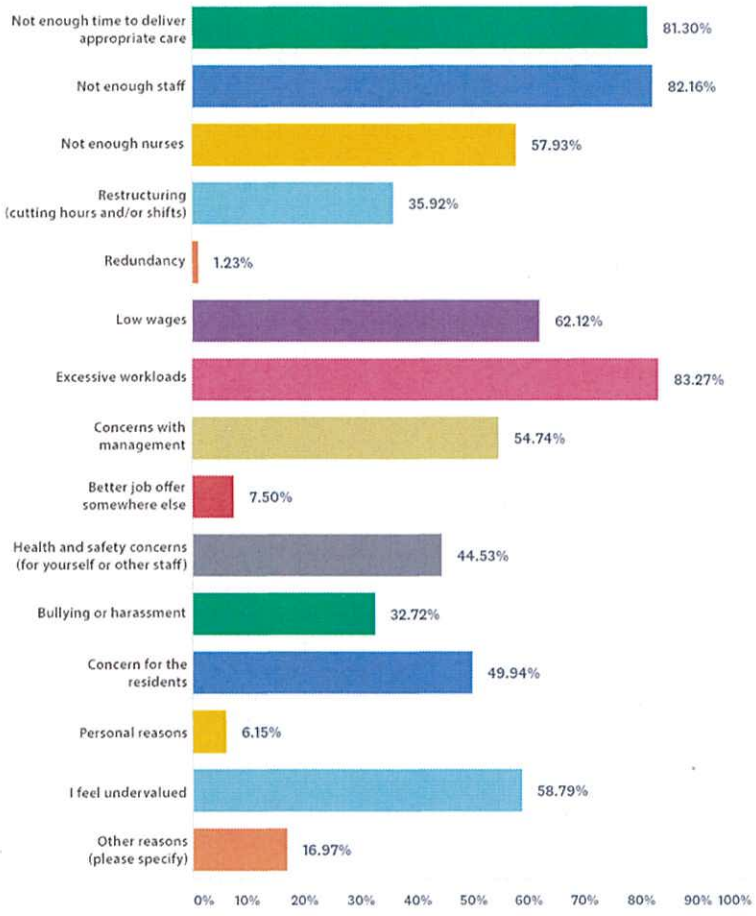


Table D

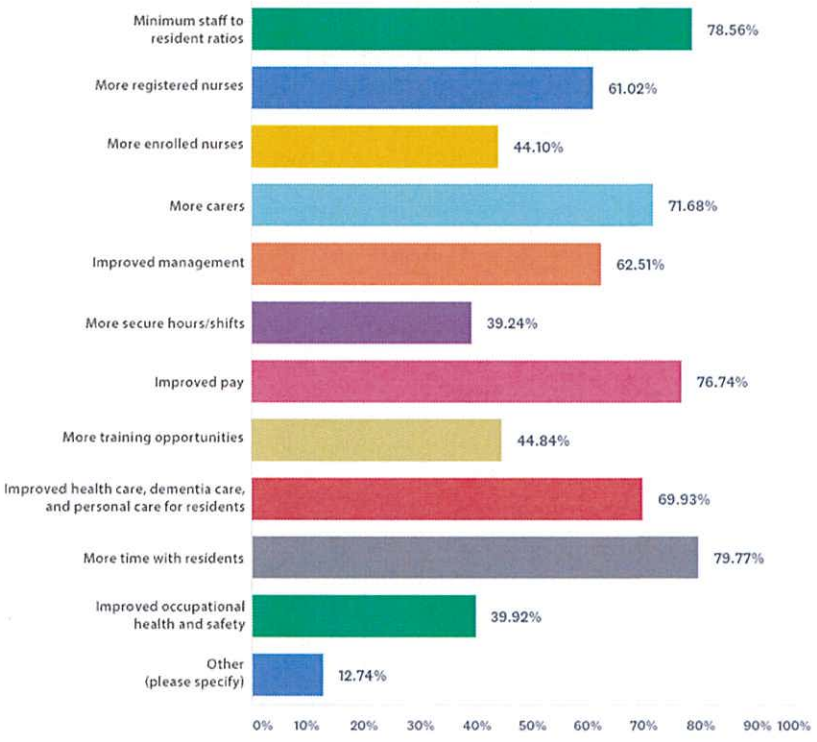
Q10 If you are considering leaving, what are the main reasons why? (you can select more than one)



250. In the survey, members were asked if they would return to aged care if improvements were made across a range of areas. Overwhelmingly, of the 1,483 who answered the question, more time with residents, minimum staff to resident ratios and improved pay were the factors that would influence their consideration. See Table E below.

Table E

Q11 Would you consider working in aged care again / or continue working in aged care if the following improvements were made: (you can select more than one)



251. Members provided hundreds of comments in response to an open question as to why they were considering leaving or had left aged care. Below is a snapshot of those comments, including an appeal to this Royal Commission:

I hope members of royal commission have worked in aged care system to get to know the real world - to get real picture of the excessive workload and how to provide holistic care to real human beings not dummies, who have multiple co morbidities. It's easier to pick on multiple issues regarding care given but it's quite difficult to deliver that care when we have 2 carers to almost 20 residents and one RN who is also a supervisor, to oversee 115 residents and that RN has to follow her own duty statement which includes 2 meds rounds in any wing of approx 15 residents and do warfarin and 2 rounds of reg DDA, on top of that- attend to emergencies, falls, consult with doctors and families, attend to care plans, Do 20 set of neuro one as 2-3 falls are expected in a day..... list is endless and it's never enough after staying back for 30 mins to an hour on average without getting paid, we walk out of door thinking I didn't have time to provide emotional support to that resident today. It's equal to looking after dummies but unfortunately our elderly are expected to compromise with the system because system knows they are helpless... and we are letting the system take advantage of them. I have worked In different aged care companies and they are all less or more same when it comes to staffing ratios. If people are serious to do something for aged care- come and work with us for at least a month, not for a day or week. You won't have to do surveys or listen to us, because you'll know by then what it means to work In aged care. Thank you for taking time to read my experience who has worked as RN for 8 years looking after elder people. Please share it with good people who wants to make a positive change.

I think after 10 years I have reached burn out. Working with violent dementia residents, going home black and blue but management won't address the issues. We are bottom of the food chain as PCA and that's exactly how it feels. Time to find something where I feel like I'm valued. Kids working on the checkouts at the supermarket get paid more per hour and have way less responsibilities

I left aged care to persue my studies as a registered nurse. At the time I was a PCA, but now as a qualified nurse I wouldn't go back due to the incredibly hard and unsafe workload. In hospitals we have ratios luckily, which is why I stay in the hospital system and wouldn't return to aged care until safe ratios and staffing are in place.

My job was my life I loved my job. The home was under new management. We had approx 24 residents per ward. At least half on each ward were hoist lifts. Only 2 carers per ward. 3 staff morning 2 in the afternoon. I was afternoon shift. Management were cutting staff back to 1carer per ward. We were expected to leave our ward to assist another ward in hoist lifts with inactive residents. The food so cut back in the evening to an extent residents went hungry to bed. As these cut backs were happening they had to cut staff. I took voluntary redundancy. This was not a caring job any longer. Broke my heart to leave after 30 yrs.

I went to Donut King the other day. There were 4 staff serving and making donuts. I manage 100 residents with the same number of staff and deal with all aspects of care.....you do the maths

Aged care culture is terrible and needs drastic change to get experienced nurses back Low pay untrained staff bad management and complex needs of residents have all formed the perfect storm for very poor aged care reform is badly needed

I felt my registration was at risk.

It's all about the money, not the resident or resident care, it's disgusting, the residents deserve so much more. I hope positive change happens soon from this enquiry, it's heartbreaking what is happening.

Aged care nurses are often talked about as inadequate or not educated enough; however, our clinical skills and decision making processes have to happen so rapidly because time for sick old people is not factored into our daily workload at all. Our decisions are often made without the support that would be available for acute presentations. Aged care nurses also cop the blame when doctors are unwilling to listen or act on the information they are provided with. Aged care needs to be brought into the light and considered as the specialty it is. I am developing an immense knowledge of medications and interactions. I have held a necrotic toe (after it fell off) in my hand; packed a half a finger deep sinus wound. Been the company and comfort for the dying. Cried on the way home, cried at home, showered and gone back to work again. Across all sectors and specialties, nurses need to have some *more darn respect for each other; then the world sees us as united and not blaming one another for the parts of life that are way beyond our control.*

As a Manager, I had no Admin Officer for the first 18 months of employment, No RN1 for the first 2 years, no support from Senior Management, but a brilliant team who I was able to upskill. I was on call 24/7 ... and I mean 24 hours 7 days per week! My last call was at midnight on a Friday night when a newly certificated PCA had a death. He was working with an agency PCA and I spent about 4 hours on the phone, talking him through final care, trying to contact the family, debriefing him, trying to contact the Regional Manager as was required when we had a death (his phone was switched off). At 4 am I went to bed, knowing that on Saturday I had to do the payroll or my staff did not get paid, and check and submit ACFIs my new graduate RN1 had completed so we could receive funding. Welcome to my world. I want to return as an RN1 on the floor but no one will employ me because of my qualifications and experience. I have three degrees ... all education and aged care related. My specialty is dementia care.

CONCLUSION

252. Many of the factors that attract people to nursing in aged care can also contribute to retaining nurses in the profession. Aged care providers have a substantial influence, as do governments, on retention of nurses. Workplace conditions, manageable workloads, legislated nurse to residential staffing and skills mix, fair, reasonable and comparable remuneration, safety and quality standards, and positive practice environments are all examples of factors which assist retention of nurses.

253. Another important factor of nurse retention has been identified as early career preparation, support and provision of opportunities, job satisfaction[92] and ongoing professional development opportunities. Supporting new graduates to transition to practice in aged care is critical to retaining nurses and ensuring a sustainable nursing workforce into the future.

254. When nurses are empowered to practice in accordance with the standards of the profession it increases work satisfaction and retention of the nursing workforce.[93] Job satisfaction is linked to opportunity and support,[94] effective, supportive and productive working relationships, access to education, effective clinical support and focused mentoring.[95]

255. The leadership and culture of an organisation also plays a central role in retention. Features of effective leadership include providing a motivational influence, being respectful and acting with integrity, role modelling, ability to resolve conflict, nurturing others by mentoring and coaching, developing staff by facilitating learning, and empowering staff.[96]

256. Working autonomously is important to many nurses, particularly those with experience. While there is potential for considerable autonomy for nurses, this is rarely realised outside the nurse practitioner role, and not always then; when combined with significant accountability, this can be a driver for people to leave the aged care sector or even the profession.

257. The ANMF submits that in order to enhance the aged care workforce's capacity and capability to provide high quality care and support good quality of life to care recipients and make the aged care sector a more attractive and rewarding place to work the following must occur as a matter of priority:

    a. Wage outcomes for aged care workers must be improved to match public sector wages.

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[92] Applebaum D; Fowler S; Fiedler N; Osinubi O; Robson M (2010). The impact of environmental factors on nursing stress, job satisfaction, and turnover intention. *Journal of Nursing Administration*, 40 (7-8): 323-8.

[93] Patrick A; Laschinger, H. (2006). The effect of empowerment and perceived organizational support on middle level nurse managers' role satisfaction. *Journal of Nursing Management* 14 (1): 13-22

[94] Zurmehly J; Martin PA; Fitzpatrick JJ (2009). Registered nurse empowerment and intent to leave current position and/or profession. *Journal of Nursing Management*, 17 (3): 383-91

[95] International College of Nursing and Midwifery (2018) *International Centre on Nurse Migration Policy brief: Nurse Retention* https://www.icn. ch/sites/default/files/inline-files/2018_ICNM%20Nurse%20retention.pdf

[96] Frankel A (2011). Leadership skills for nurses: what leadership styles should senior nurses develop? *Nursing Times Supplement*. Online at https://www.nursingtimes.net/Journals/2011/08/24/j/n/i/Leadership-Skills-for-Nurses.pdf

b. The aged care sector should be supported to overcome the systemic barriers to achieving wage parity and improved working conditions.
c. Safe work practices and design must be promoted
d. Government funding of aged care must be transparent and accountable.
e. Both Government and providers must demonstrate accountability with respect to funding allocated to wages.
f. Funding must be linked to quality of care outcomes and determined through an evidence based methodology
g. The aged care sector must be supported and promoted through policy and funding as an essential and valued part of the health sector. This is achieved through education pathways, transition to the workforce and career development.
h. Positive cultural perceptions of aging and elderly people and those who care for them must be promoted
i. The currently unregulated aged care workforce must become subject to minimum education and training standards and be regulated to ensure delivery of quality and safe care.

258. Most importantly, minimum staffing ratios (numbers) and skills mix (type) must be legislated (made law) in residential aged care, in accordance with the ANMF's project, i.e. a national average of 4.3 hours of care per day with a skills mix of 30% RN/20% EN/50% Care workers.

259. These mandated requirements should be implemented in accordance with *the Plan* (*Aged care ratios make economic sense*)[97].

260. Finally, the ANMF directs the Commission's attention to the Commonwealth Government's view on workforce needs and skills mix. It is as follows:

"Government's view is that aged care providers are best able to determine their workforce needs and staff skill mixes. This is because the relationship between staffing and aged care homes and the quality of the care provided is complex."

(See letter from Senator The Honourable Richard Colbeck to Ms Beth Mohle, Secretary, Queensland Nurses and Midwives' Union dated 20 September 2019. Annexed and marked **ANM.0013.0004.0001**.)

261. The ANMF utterly rejects that view as inconsistent with the experience of residents, their families, nurses, care workers, doctors, academic studies and the overwhelming evidence before the Commission. It is deeply troubling and underscores the importance of the Royal Commission's work.

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[97] ANM.0001.0001.3341

Australian Nursing & Midwifery Federation

ANMF Policy

International recruitment of nurses and midwives

Preamble

The movement of nurses and midwives between countries is an international phenomenon contributing to the personal and professional development of individual nurses and midwives and to the provision of nursing and midwifery care.

While international mobility of nurses and midwives is nothing new, there now exists large scale, targeted, international recruitment by developed countries to address domestic shortages.

In Australia, international recruitment is a strategy that is regularly utilised to resolve workforce shortages.

Recruitment of nurses and midwives from less resourced countries to meet the healthcare needs of well-resourced nations is of such growing concern the World Health Organisation declared that active recruitment of healthcare workers and its related migration as one of the greatest global health threats in the 21st century. [1]

Governments must acknowledge the issue at a local level by implementing strategies that properly plan and manage the domestic nursing and midwifery workforce.

A primary strategy must include inter-government agreements which protect the interests of host and source countries, with particular acknowledgment of the need to minimise the negative impacts on the provision of health services in developing countries.

It is the policy of the Australian Nursing and Midwifery Federation that:

1. The implication of global competition for nurses and midwives necessitates ethical consideration, as aggressive recruitment from developing countries may have potentially unwanted consequences for the health systems of the source country(ies).

2. Overseas recruitment programs must not be used as a primary strategy to overcome nursing and midwifery shortages in Australia and internationally, or as an alternative to educational opportunities for the existing nursing/midwifery workforce.

3. Overseas working visa programs should not be utilised by Australian Governments of any level as a solution to the underemployment or unemployment of Australian graduate nurses and midwives.

4. Governments must commit more resources for workforce planning, education and improving pay and conditions in order to attract and retain nurses.

5. Employers wishing to recruit nurses and midwives internationally must:

    - Have introduced a range of strategies aimed at attracting, recruiting and retaining nurses and midwives residing in Australia;
    - Provide internationally recruited nurses and midwives with employment conditions the same as those offered to nurses and midwives in Australia; and
    - Meet the Australian Department of Immigration requirements.

6. Employers who recruit nurses and midwives internationally must not:

    - Charge nurses and midwives excessive costs for transport and accommodation associated with recruitment (or allow agents acting on their behalf to do so);

- Charge nurses and midwives for recruitment agency costs incurred in the country of origin;
- Dismiss a nurse or midwife on a work visa without providing them with due process or adequate warning and an opportunity to find other employment before reporting the termination of employment to the Department of Immigration.

7. Prior to the recruitment of international nurses and midwives, employers must exhaust all avenues to employ nurses and midwives domestically. The employer must demonstrate that they have undertaken appropriate market testing, by all available means, to ensure that any local nurses and midwives who may be potential candidates are aware of the employment opportunity.

8. Employers seeking to recruit and employ nurses and midwives from other countries must provide the following:

- Transparency and fairness in recruitment practice;
- Effective human resource planning and development including mentoring and orientation;
- Full access to employment opportunities and flexible environments;
- Standards, Terms and Conditions consistent with the domestic workforce;
- Freedom from discrimination;
- The right to be informed regarding freedom of association; and
- Assistance to meet the necessary Nursing and Midwifery Board of Australia (NMBA) Registration Standards including the English Language Skills Standard as well as the requirements for recognition of the nurses/midwives overseas qualifications as determined by the NMBA.

9. Employers of nurses and midwives in Australia must be required to recognise experience gained overseas which is assessed at a comparable standard for the purpose of experience and incremental payments.

10. Procedures for the assessment of nursing and midwifery applications from other countries must be equitable and fair, be based on nationally agreed proficiency in English language, determine that all other NMBA Registration Standards have been met, and recognise previous experience and prior formal educational qualifications.

11. Nurses/midwives who choose to move overseas must have their overseas work of a comparable standard recognised in Australia for the purposed of retention of their registration with the NMBA.

12. The ANMF Federal Office is the central point for all enquiries from international recruitment companies or any other source seeking information regarding the recruitment of nurses and midwives from overseas.

Endorsed June 1998
Reviewed and re-endorsed November 2004
Reviewed and re-endorsed December 2007
Reviewed and re-endorsed August 2008
Reviewed and re-endorsed June 2011
Reviewed and re-endorsed May 2015
Reviewed and re-endorsed May 2018

Reference

1. Shaffer et al. *Human Resources for Health* 2016. 14(Suppl 1):31. Available at: http://www.intlnursemigration.org/wp-content/uploads/2014/09/s12960-016-0127-6.pdf

ANMF Submission

EDUCATING THE NURSE OF THE FUTURE - INDEPENDENT REVIEW OF NURSING EDUCATION

4 JULY 2019

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CONTENTS

TERMS OF REFERENCE

Educating the Nurse of the Future - Independent Review of Nursing Education

AIM: the outcome from this Review is to ensure that the preparation of nurses meets the service needs of the future health system. The Review will be forward focussed and give consideration to the attraction into nursing, international competitiveness of Australian based education programs and articulation and career paths of the preparation programs for Enrolled Nurses, Registered Nurses and Nurse Practitioners.

TERMS OF REFERENCE

To examine:

- *the effectiveness of current educational preparation of and articulation between enrolled and registered nurses and nurse practitioners in meeting the needs of health service delivery*
- *factors that affect the choice of nursing as an occupation, including for men*
- *the role and appropriateness of transition to practice programs however named.*
- *the competitiveness and attractiveness of Australian nursing qualifications across international contexts*

To consider:

- the respective roles of the education and health sectors in the education of the nursing workforce

To make recommendations on:

- educational preparation required for nurses to meet future health, aged care and disability needs of the Australian community including clinical training
- processes for articulation between different levels of nursing
- mechanisms for both attracting people to a career in nursing (both male and female) and encouraging diversity more broadly

To have regard to:

- regional needs and circumstances
- national and international trends, research, policies, inquiries and reviews related to nursing education

EXECUTIVE SUMMARY

Since its establishment in 1924 the Australian Nursing and Midwifery Federation (ANMF) has been a major contributor and key stakeholder in the education of nurses in Australia. The organisation's members and officials have taken leadership roles in evolving nursing education over the years to equip nurses for a rapidly changing health care environment. The most significant historical aspect of this was establishing education for nurses within the scholarly rigorous, research based atmosphere of the tertiary sector, to receive a comparable professional foundation to that of our healthcare practitioner colleagues. Continuing work has included considerable contributions to the regulatory framework which governs nursing education and practice. Our essential aim is to ensure both that nurses receive the most appropriate and high quality education which prepares them to be safe, competent practitioners, and, to have workplaces that are conducive to them being able to deliver care which meets the Australian community's health care needs.

The ANMF considers the education of nurses in Australia prepares safe and competent practitioners able to meet the challenges of our increasingly complex domestic health care system and to practice effectively in settings beyond our shores. We therefore welcome the opportunity afforded by the *Educating the Nurse of the Future – Independent Review of Nursing Education* to comprehensively evaluate the way nurses in Australia are prepared for practice both for initial entry to nursing and then to the advanced practice level of the nurse practitioner.

This submission provides an outline of the current structures of nursing education in Australia and the context within which this review is placed, detailing the three levels of regulated nursing qualification in Australia, namely: registered nurse, enrolled nurse, nurse practitioner. In addressing the four terms of reference of the review, the submission focuses on the practical experiences of ANMF members as they have journeyed through preparatory education to transition into the workforce as beginning healthcare practitioners. These real-life member experiences are supported by national and international evidence which has then been used to underpin recommendations to the review process. In framing the seventeen recommendations, the ANMF has sought to identify issues and solutions which will best place the professional education for nurses in Australia to meet future challenges posed by ever increasingly rapid changes in health and aged care needs.

SUMMARY OF RECOMMENDATIONS

Recommendation 1

That the Australian Nursing and Midwifery Accreditation Council (ANMAC) collect both quantitative and qualitative data on student attrition rates, making the annual de-identified data publicly available.

Recommendation 2

That an evidence-based framework be identified in the ANMAC *Registered Nurse Accreditation Standards*, to provide a clear minimum requirement for support for undergraduate students on clinical placement, such as the Best Practice Clinical Learning Environment Framework (BPCLEF).

Recommendation 3

That the ANMAC *Registered Nurse Accreditation Standards* require minimum clinical placement hours for the Bachelor of Nursing to be increased from 800 to 920 hours, an additional three weeks.

Recommendation 4

That ANMAC be funded to conduct independent research to explore the issues of quality and quantity of clinical placement hours in the bachelor program leading to registration as a registered nurse.

Recommendation 5

That an evidence-based framework be identified in the ANMAC *Enrolled Nurse Accreditation Standards*, to provide a clear minimum requirement for support for students on clinical placement, such as the Best Practice Clinical Learning Environment Framework (BPCLEF).

Recommendation 6

That ANMAC be funded to conduct independent research to explore the issues of quality and quantity of clinical placement hours in the Diploma of Nursing program leading to registration as an enrolled nurse.

Recommendation 7

That there is improved communication to employers, other health practitioners and the nursing profession by the Nursing and Midwifery Board of Australia and the vocational education and training sector regarding the practical skills, competencies, and scope of enrolled nursing practice.

Recommendation 8

That federal, state, and territory governments offer financial incentives to health care providers to employ and utilise nurse practitioners in health services, with additional incentives to nurse practitioners who work in districts of workforce shortage.

Recommendation 9

That federal, state, and territory governments provide additional funding for registered nurses to undertake the Masters of Nurse Practitioner programs leading to endorsement as a nurse practitioner.

Recommendation 10

That federal, state and territory governments provide scholarships to support Aboriginal and Torres Strait Islander peoples to undertake nursing programs of study which lead to registration as a nurse or endorsement as a nurse practitioner.

Recommendation 11

That federal, state and territory governments collaborate with the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) to develop and expand initiatives that support Aboriginal and Torres Strait Islander peoples to undertake and complete nursing programs.

Recommendation 12

That federal, state and territory governments fund transition to practice programs for enrolled nurse graduates in acute, aged, primary, and community health settings.

Recommendation 13

That an evidence-based framework for support be consistently applied across the country by federal, state and territory governments for all transition to practice programs, such as the *Victorian Nursing and Midwifery Transition to Practice Programs Guidelines 2018.*

Recommendation 14

That the Nursing and Midwifery Board of Australia (NMBA) add a question to the annual re-registration survey asking new registrants if they were provided with support and education during their first year of practice, and whether this was informal or a structured transition to practice program.

Recommendation 15

That the undergraduate program re-evaluate the importance of educating students about the provision of aged care, emphasising the skill and expertise needed to provide safe, quality care to this population.

Recommendation 16

That all nurses have access to clinical supervision as a continuous professional development strategy for providing ongoing learning, support and self-care.

Recommendation 17

That education about the principles of clinical supervision be embedded in all nursing undergraduate and vocational education.

PREAMBLE

The Australian Nursing and Midwifery Federation (ANMF) is Australia's largest national union and professional nursing and midwifery organisation. In collaboration with the ANMF's eight state and territory branches, we represent the professional, industrial and political interests of 275,000 nurses, midwives and carers across the country.

Our members work in the public and private health, aged care and disability sectors across a wide variety of urban, rural and remote locations. We work with them to improve their ability to deliver safe and best practice care in each and every one of these settings, fulfil their professional goals and achieve a healthy work/life balance.

Our strong and growing membership and integrated role as both a professional and industrial organisation provide us with a complete understanding of all aspects of the nursing and midwifery professions and see us uniquely placed to defend and advance our professions. Through our work with members we aim to strengthen the contribution of nursing and midwifery to improving Australia's health and aged care systems, and the health of our national and global communities.

As the largest professional organisation for nurses and midwives in Australia, the ANMF has, on behalf of our members, a genuine interest in, and concern for, matters relating to the education of nurses and midwives. The ANMF provides this submission with extensive expertise in nursing education, both from a professional and industrial perspective. Since its establishment in 1924, the ANMF has been instrumental in all educational advancement for registered nurses and enrolled nurses and more recently with the developing role of nurse practitioners. We have contributed significantly, and continue to do so, to a range of committees and working groups at national and jurisdictional levels, which relate to the design, accreditation and evaluation of education programs for all registered nurses, enrolled nurses and nurse practitioners.

INTRODUCTION

While nursing education in Australia has evolved and undergone continuous improvement since the last nursing education review in 2002, the ANMF welcomes this opportunity to comprehensively evaluate the way nurses in Australia are prepared for the profession both on initial entry to practice and the advanced practice of the nurse practitioner.

This submission provides an outline of the current structures of nursing education in Australia and the context within which this review is placed, detailing the three levels of regulated nursing qualification in Australia. The submission then addresses the four terms of reference, focusing on the practical experience of the ANMF members and supported by national and international evidence to underpin our recommendations.

In the first section, the submission examines the effectiveness of current education of registered nurses, enrolled nurses, and nurse practitioners, exploring for each the aspects that work well and why, what is missing from our current education systems, why these unaddressed factors matter, and how to address these shortfalls.

The second section of the submission focuses on the factors that attract people to the nursing profession, identifying what factors are working well and areas that need improvement.

The third section outlines the role of transition to practice programs, and how they are currently delivered and funded. This section also suggests evidence based solutions to improve transition program support for consistency across the country.

The fourth section describes the importance of educating nurses firstly for the Australian context then compares Australian nursing qualifications to international equivalents for benchmarking purposes. A comparison is made with five countries (New Zealand, England, Canada, the United States, and Singapore).

The last section of the submission outlines the future focus for nursing education. It identifies a number of health priorities that will require expansion of nursing care, which will in turn require nursing education to continue to adapt content and practice in undergraduate programs. This will be essential to ensure the education of nursing keeps pace with Australia's future healthcare needs.

BACKGROUND

The nature and societal expectation of health care shifted rapidly in the 1960s, when the invention of cardio-pulmonary resuscitation and the introduction of intensive care units began to extend medical potential. Hand in hand with the expansion of medicines and surgical interventions that could treat formerly fatal conditions like diabetes and cancers, these innovations expedited the transformation of health care in the developed world from a predominant focus on acute, accident, and emergency medicine to an increasing emphasis on preventative health and management of chronic diseases and conditions.

As a result of the success of these medical advances, people are living longer – diseases and conditions that would have caused death only a generation earlier can very often be effectively managed or cured. However, the longer we live the more likely we are to develop diseases, and the longer we live with chronic disease, the more likely we are to experience complications. This has resulted in an increased demand for acute care, supportive or chronic disease management, and supported care in the community or in residential facilities.

This increasing need potentially poses two problems for the profession: how do we continue to equip nurses to meet these needs, and how do we ensure that there are, and will continue to be, enough nurses to provide the care our ageing and increasingly medically complex population requires.

The last systemic national review of nursing education was in 2002. There have been three significant reforms to nursing education and regulation in the intervening period.

In 2005 a Productivity Commission report on issues and proposed solutions to issues affecting the health care workforce, proposed that the Council of Australian Governments introduce a single national registration board for all health practitioners, in order to assure the ongoing delivery of safe, quality care.[1] The recommendation was based on a review that found the then-current system of state/territory based accreditation, regulation, and registration for the health professions was "complex, poorly coordinated, and insufficiently responsive to changing needs and circumstances."[2] In response, the transfer from state and territory boards to the National Nursing and Midwifery Board of Australia (NMBA) came into effect on 1 July 2010.

Concurrent with the move to national registration, the Australian Nursing and Midwifery Accreditation Council (ANMAC) was appointed to ensure that Australian courses leading to registration meet the NMBA's approved accreditation standards. These changes have not only simplified registration for nurses practicing across regions, but has also ensured national consistency of standards and education programs through vestment of accreditation authority with the Council. That nurses so easily cross state/territory jurisdictions and practice without impediment, difficulty, or need for additional education demonstrates that the current education systems and safeguards are robustly adequate to meet Australian health care needs nationally, across all contexts of practice.

These changes have not only simplified registration for nurses practicing across regions, but have also ensured national consistency of standards and education programs through vestment of accreditation authority with ANMAC and subsequent scrutiny and approval by the NMBA.

That nurses may easily cross state/territory jurisdictions and practice without impediment, difficulty, or need for additional education demonstrates that the current education systems and safeguards are robustly adequate to meet Australian health care needs nationally, across all contexts of practice.

Nurses comprise the single largest professional group within health care, and practice across all sectors, in all geographical regions, in three defined levels of scope. These levels include the registered nurse, the enrolled nurse and the nurse practitioner, which are detailed in the following section.

In the United States, the National Academies of Sciences, Engineering, and Medicine has called on nurses to take a bigger role in America's health care system to help meet increasingly complex and changing demands, recommending that nurses be full partners, with physicians and other health care professionals, in redesigning health care in the United States.[3] Australia's nurses too have, and will continue to play, an integral role in not only the delivery but also the design and priorities of health care across this nation.

This submission will address the issues raised in the Terms of Reference, and provide recommendations to ensure Australia's health care sector continues to have a safe, competent, flexible nursing workforce that can meet the evolving needs of our population. In the process of doing so, this report will investigate a number of issues that contribute to current and future barriers to achieving this goal, and explanations of how the recommendations will address and overcome them.

CURRENT CONTEXT

In Australia there are two categories of nurse regulated to practice: the registered nurse and the enrolled nurse. A registered nurse is a person who has successfully completed the prescribed Australian Nursing and Midwifery Accreditation Council (ANMAC) accredited education program and has acquired the requisite qualification to be a registered nurse with the Nursing and Midwifery Board of Australia (NMBA). The registered nurse undertakes initial and ongoing assessment of nursing care needs, supervises and delegates aspects of care to the enrolled nurse. Nurse practitioners are a further category of nurse, however one that builds upon the practice of the registered nurse. Below, the NMBA's orientating statements and descriptions of the standards of practice for registered nurses, enrolled nurses, and nurse practitioners have been included to describe the expectations and requirements of these categories of nurse in Australia.

The role of the generalist registered nurse

The national registered nurse standards for practice prepared by the NMBA provide a clear and relevant summary of the role of the registered nurse in Australia. They are broad and principle-based so that they are sufficiently dynamic for practising nurses and nurse regulators to use as a benchmark in a range of settings.

A relevant excerpt from the NMBA Registered Nurse Standards for practice is:

The registered nurse provides evidence-based nursing care to people of all ages and cultural groups, including individuals, families and communities. The role of the registered nurse includes promotion and maintenance of health and prevention of illness for individuals with physical or mental illness, disabilities and/or rehabilitation needs, as well as alleviation of pain and suffering at the end stage of life.

The registered nurse assesses, plans, implements and evaluates nursing care in collaboration with individuals and the multidisciplinary health care team so as to achieve goals and health outcomes. The registered nurse recognises that ethnicity, culture, gender, spiritual values, sexuality, age, disability and economic and social factors have an impact on an individual's responses to, and beliefs about, health and illness, and plans and modifies nursing care appropriately.

The registered nurse provides care in a range of settings that may include acute, community, residential and extended care settings, homes, educational institutions or other work settings and modifies practice according to the model/s of care delivery.

The registered nurse takes a leadership role in the coordination of nursing and health care within and across different care contexts to facilitate optimal health outcomes. This includes appropriate referral to, and consultation with, other relevant health professionals, service providers, and community and support services. The registered nurse contributes to quality health care through lifelong learning and professional development of herself/himself and others, research data generation, clinical supervision and development of policy and clinical practice guidelines. The registered nurse develops their professional practice in accordance with the health needs of the population/ society and changing patterns of disease and illness.

The standards for practice for the registered nurse are organised into domains: professional practice, critical thinking and analysis, provision and coordination of care, and collaborative and therapeutic practice.[4]

These Australian national standards for practice for the registered nurse are the core standards by which registered nurses' performance is assessed to obtain and retain registration as a registered nurse in Australia. They provide a framework for assessing practice, and are used by the NMBA as part of the annual renewal of registration, to assess nurses who are: educated overseas seeking to work in Australia, returning to work after breaks in practice, or involved in professional conduct matters.

The NMBA can also apply these standards in order to communicate to consumers the standards that they can expect from nurses. Universities use the standards when developing nursing curricula, and to assess student readiness for practice and new graduate performance.

The standards are research based and were developed using the best possible evidence, including using information and feedback provided by nurses in a variety of settings. The principles of assessment for the standards can also be helpful for understanding how the standards may be used to assess performance.

The registered nurse demonstrates that they are capable of meeting the needs of the provision of nursing practice as specified by registration requirements, NMBA standards and codes, educational preparation, relevant legislation, and the context that care is delivered within. The registered nurse practises independently and interdependently, assuming accountability and responsibility for their own actions and delegation of care to enrolled nurses and health care workers. Delegation takes into consideration the education and training of enrolled nurses and health care workers and the context of care.

The role of the enrolled nurse

An enrolled nurse (EN) is a person with appropriate educational preparation and competence for practice and has acquired the requisite qualification to be an enrolled nurse with the NMBA. The enrolled nurse provides nursing care, working under the direction and supervision of the registered nurse.

The enrolled nurse standards for practice are the core standards that provide the framework for assessing enrolled nurse practice. As with the standards for practice for the registered nurse (above), they are prescribed by the NMBA:

T*he enrolled nurse works with the registered nurse as part of the health care team and demonstrates competence in the provision of person-centred care. Core practice requires the enrolled nurse to work under the direct or indirect supervision of the registered nurse. At all times, the enrolled nurse retains responsibility for his/her actions and remains accountable in providing delegated nursing care. The need for the enrolled nurse to have a named and accessible registered nurse at all times and in all contexts of care for support and guidance is critical to patient safety. Although the scope of practice for each enrolled nurse will vary according to context and education, the enrolled nurse has a responsibility for ongoing self and professional development to maintain their knowledge base through life-long learning, and continue to demonstrate the types of core nursing activities that an enrolled nurse would be expected to undertake on entry to practice. Therefore the core standards in this document are the minimum standards that are applicable across diverse practice settings and health care populations for both beginning and experienced enrolled nurses. They are based on the Diploma of Nursing being the education standard. ENs engage in analytical thinking; use information and/or evidence; and skilfully and empathetically communicate with all involved in the provision of care, including the person receiving care and their family and community, and health professional colleagues.*

The enrolled nurse standards are clinically focused and they reflect the enrolled nurse capability to provide direct and indirect care, engage in reflective and analytical practice, and demonstrate professional and collaborative practice.

Enrolled nurses, where appropriate, educate and support other (unregulated) health care workers (however titled) related to the provision of care. Enrolled nurses collaborate and consult with health care recipients, their families and community as well as registered nurses and other health professionals, to plan, implement and evaluate integrated care that optimises outcomes for recipients and the systems of care. They are responsible for the delegated care they provide and self-monitor their work. Three domains capture the elements which make up the NMBA enrolled nurse standards for practice: professional and collaborative practice, provision of care, and reflective and analytical practice.[5]

The enrolled nurse standards communicate to the general public the standards that can be expected from ENs and can be used in a number of ways including the development of nursing curricula by education providers, assessment of students and new graduates, assessing the standard of nurses educated overseas seeking to work in Australia and Australian-trained ENs returning to work after breaks in practice, and to assess professional conduct or matters relating to notifications.

These standards reflect the role of the enrolled nurse within the health environment. The standards for practice remain broad and principle-based so that they are sufficiently dynamic for practising nurses to use as a benchmark in a range of settings.

The role of the nurse practitioner

The nurse practitioner NMBA standards for practice are the core practice standards that provide the framework for assessing the nurse practitioner role and practice. As with the standards for practice previously cited, they are prescribed by the NMBA:

Nurse practitioners have the capability to provide high levels of clinically focused nursing care in a variety of contexts in Australia. Nurse practitioners care for people and communities with problems of varying complexity. The nurse practitioner scope of practice is built on the platform of the registered nurse scope of practice, and must meet the regulatory and professional requirements for Australia including the Registered nurse standards for practice and Code of conduct for nurses.

When assuming the title and scope of practice of a nurse practitioner, the nurse practitioner understands the changes in the scope of practice from that of a registered nurse, and the ways that these changes affect responsibilities and accountabilities.

Fundamentally, a nurse practitioner provides nursing care within their regulated scope. The core standards of the nurse practitioner are the minimal standards that are applicable across diverse practice settings and patient/client populations for both beginning and experienced nurse practitioners. Nurse practitioner attributes are consciously cultivated through formal learning that includes a work-based component.

The educational requirement for endorsement of nurse practitioners in Australia is a Masters degree. This formal learning builds on demonstrable advanced practice within the registered nurse scope. The nurse practitioner has a high degree of systems literacy and can manage care across a variety of health systems to maximise outcomes; nurse practitioners engage in complex and critical thinking; integrate information and/or evidence; judiciously use clinical investigations; and skilfully and empathetically communicate with all involved in the care episode, including the person receiving care and their family and community, and health professional colleagues. Nurse practitioner attributes are clinically focused; they are capable in research, education and leadership as applied to clinical care. Research includes processes to support reflective practice, evidence-based care and quality management. The nurse practitioner has the capability to educate others related to the focus of, and available options, of care. Nurse practitioners are leaders and have an ability to lead care and care teams. They engage in reflective practice and support others in this process through clinical supervision or mentoring. Nurse practitioners can manage episodes of care, including wellness focused care.

Nurse practitioners may be the primary provider of care or part of a care team. They collaborate and consult with health consumers, their families and community, other professionals, including health personnel, to plan, implement and evaluate integrated care that optimises outcomes for recipients and the systems of care. As part of providing care, nurse practitioners can order and interpret investigations to facilitate diagnosis and care planning. Care may include nursing interventions that involve initiation, titration or cessation of medications. Nurse practitioners take responsibility for following-up on any components of care initiated.

They are accountable for care provided and self-monitor their work. Four domains capture the standards for practice which make up the NMBA standards for the nurse practitioner: clinical, education, research, and leadership.[6]

A benchmarking of the delivery, evaluation, and scope of these roles with their international equivalents is discussed under the fourth term of reference.

SUMMARY

Having outlined the regulatory context within which Australia's nursing education systems currently sit, we will address the first term of reference, and explore the effectiveness of these methods to prepare registered nurse, enrolled nurses, and nurse practitioners to meet the needs of Australians, and how nurses can articulate from one level to the next.

TERMS OF REFERENCE 1

The effectiveness of current educational preparation of an articulation between enrolled and registered nurses and nurse practitioners in meeting the needs of health services delivery

INTRODUCTION

Nursing is a multifaceted, demanding and rewarding profession that relies upon the possession of a comprehensive knowledge base and the ability to apply that knowledge and clinical skills in the health care setting. In doing so, nurses are required to master an array of often complex clinical activities and procedures, exercise decision making and critical thinking, demonstrate clear communication and interpersonal skills, and continuously assess, implement, evaluate, and re-prioritise care to meet the often rapidly changing health conditions of the people for whom they are caring. Nurses do so with an understanding of the legal, ethical and professional framework which governs their practice.

"Nurses are in the best position to initiate actions that minimise adverse events and negative outcomes for patients."[7] It is therefore essential that the educational preparation for these roles is rigorous, with an appropriate mix of theory and clinical practice experience. Within this, it is imperative that the educational preparation of nurses continues to prioritise and focus on promoting the critical thinking and decision making capacity necessary for adequately preparing new nurses for the constantly evolving and unpredictable clinical settings in which they will practice.

The current nursing education system in Australia is world-class and produces globally employable nursing graduates. It produces effective, highly skilled and knowledgeable clinicians who comprise the greatest proportion of health care practitioners, and work across all health care settings, in every geographical region.

In this section we will discuss the effectiveness of current education of registered nurses, enrolled nurses, and nurse practitioners, exploring for each what aspects work well, and why, what is missing from our current education systems, why these unaddressed factors matter and how these shortfalls should be addressed.

Registered nurses

Current education preparation for registered nurses

Australia was the first country to achieve the transfer of all registered nurse undergraduate education to the tertiary sector,[8] a feat begun in 1986 and completed by 1993.[9] The majority of undergraduate degrees are offered over three years full time, with mid-program entry available to candidates with previous tertiary qualifications, and for enrolled nurses articulating to a higher level within the profession. There are also longer, dual degree programs that partner nursing with a second discipline (most commonly midwifery but other options include paramedicine, psychology, and public health and health promotion).

The Bachelor of Nursing provides a comprehensive generalist foundation approach to the profession which is the backbone of health care delivery in Australia. The bachelor provides a platform on which graduates can build post-registration specialisation across the entire array of nursing practice areas. This allows for both greater individual choices throughout their career, and a flexible, adaptable workforce.

While the content is created and reviewed with input from other disciplines and consumers, it is nurse-led, which ensures its authenticity informed by the educators' professional experience, and that profession-specific information is contemporary and consistent. The university setting means that each education program is created by academics who are not only immersed in nursing practice, but who also conduct nursing research, ensuring the delivery of strong, evidence-based content that addresses national health strategies. Research theory is embedded through the degree encouraging students to examine the theory underlying real world practice, and provides a path to nurse academia for all registered nurse graduates.

While there are mandatory minimum components (including clinical placement hours, and the inclusion of Aboriginal and Torres Strait Islander health issues), and every degree is overseen by the national accreditation authority, each degree is unique; this allows for consistency without being prescriptive, and encourages innovation.

What makes it effective?

Registered nurses are an embedded, integral part of the Australian health sector and make a positive difference to patient outcomes. Australia has patient outcomes that measure well against world standards. A national registration and accreditation system in Australia provides effective regulation to ensure public safety through registered nurses meeting the required NMBA standards. The notifications through this scheme are very low for registered nurses,[10,11] compared to other professions therefore suggesting the educational preparation of registered nurses is meeting the regulatory standards for public safety.

As mentioned in both the introduction section and above, another one of the clear strengths of the current regulatory framework is ANMAC - a centralised, national, independent, profession specific accrediting authority, which ensures that degree content is consistent with the national accreditation standards, without requiring universities to produce identical content. This wide scope ensures minimum standards but allows for a variety of approaches across all aspects of the education experience, from the type of content to delivery of that content across different media, in a range of formats. This allows students to utilise the learning styles that best suit their needs.

ANMAC accreditation standards also require minimum entry criteria including minimum English language skills. These are essential to reduce the likelihood of admitting students who are unable to complete the program. The minimum requirements allow universities to set their own selection criteria, enabling flexibility for students with diverse needs and for local community requirements.

ANMAC as the profession specific regulator works closely with the Tertiary Education Quality and Standards Agency (TEQSA), the regulator for the Australian higher education sector. TEQSA's purpose is to protect student interests and to ensure quality assurance.[12] These two regulators have different purposes and work together to minimise duplication and share relevant risk intelligence.

The dual regulation requirements of ANMAC and TEQSA's governance frameworks in universities result in programs that are reviewed regularly to ensure they are meeting the needs of the profession and the health outcomes of Australia. One of these requirements is continual evaluation to ensure program content remains relevant and that emerging population health issues (for example, aged, chronic, preventative, and primary care) and national health priorities are reflected in content delivery.

Current education delivery is a combination of substantial theory across multiple areas of clinical expertise. Delivery of theoretical content is balanced with the opportunity for students to practice clinical skills, consolidate different types of knowledge, and develop dexterity (for example, performing dressings while maintaining asepsis, and mixing and drawing up medications quickly and accurately). Universities use a mix of laboratory sessions (to practice individual skills and dexterity), simulation sessions (where students need to integrate class learning, underpinning theory, patient assessment, and problem-solving), and *in vivo* clinical placements. ANMAC's mandated minimum of 800 hours of clinical experience ensures real world experience, with multiple components allowing students a more encompassing picture of clinical practice than is possible with simulation alone.

Pre-registration students gain clinical experience in a wide variety of settings, from residential aged care to community environments, from rural placements to time in acute quaternary hospitals. When it works best, undergraduate education is a partnership between education providers and clinical facilities. These clinical hours are supported by experienced, expert registered nurses who are able to role model, teach and evaluate student performance while delivering quality care.

Intra-professional learning is occurring in many ways within registered nurse education. Nurse and midwife academics within universities engage in cross disciplinary activities, such as research, with their colleagues in other academic health disciplines, and, students of nursing and midwifery programs engage in inter-professional learnings (both in theoretical/simulated and practice environments). The benefits of these inter-professional collaborative activities are multifaceted: for awareness raising of the different scopes of practice of each professional discipline, and, for gaining an appreciation and respect for the decision-making and contribution of each professional group to healthcare. Essentially, exposure of health professionals to one another during their entry-level education provides an understanding of one another's roles and the foundation for effective multidisciplinary healthcare teams. The ANMF considers the current incorporation and presentation of these issues in nursing education to be satisfactory.

The features of current education that are problematic/missing- why and what's the solution?

Attrition

While nursing is an attractive option for many people with degree programs close to being fully subscribed, not all candidates complete their qualification, not all graduates register with NMBA, and the days of nursing as a lifetime career are waning.[13] While we know this anecdotally, we do not have access to clear and informative national rates of attrition, and therefore, data relating to students not completing the program. There is little research and no national collective numbers that can be compared year to year. Without both quantitative information (how many people and their demographics), informed by qualitative data (why they leave, and what factors would change this), we cannot effectively address the contributing issues.

The ANMF considers that ANMAC is in the perfect position to collect and analyse attrition data and to make de-identified information publicly available. This data could be used to inform accreditation and monitoring work of ANMAC and assist with workforce planning at a national level.

ANMF recommends:

That the Australian Nursing and MIdwifery Accreditation Council (ANMAC) collect both quantitative and qualitative data on student attrition rates, making the annual de-identified data publicly available.

Workforce numbers

The current rate of graduates registering is generally meeting graduate vacancies in both the public and private health settings.[14] However, we are less than a decade away from a consistently predicted national and international nursing shortage,[15] as older nurses, who are also the most experienced clinicians, transition out of the profession. Accepting more students and increasing numbers of early-career international nurses will not alone adequately meet projected workforce needs. Further work needs to be completed to ensure future workforce planning continues to ensure the required numbers of registered nurses are graduating while also retaining experienced registered nurses in the current workforce. This will ensure a skills mix for safe, competent nursing care.

Clinical placements

When done well, clinical placements effectively prepare students as beginning level practitioners, for the workplace. The ANMF's student and nurse members tell us regularly however about inadequate clinical placement experiences. Achieving quality clinical placement experiences can be difficult; the ANMF acknowledges that the space education providers have to compete in to negotiate quality clinical placements is both onerous and complex, and is driven by a number of factors.[16] These include:

- competition for places by increasing student numbers, both in nursing and from other health disciplines, alongside post-graduate nursing students;
- gaps in partnership arrangements between education providers and health care settings providing placement opportunities, resulting in a lack of transparency and oversight and, on occasion, little opportunity for education providers to influence how the clinical placement is experienced by students;
- the impost of students, via providers, of unregulated and variable placement costs – the ANMF has been told by education providers that they can be charged from $55 to in excess of $120 per student per day. We note that this is a trend that has emerged over the last decade, and is only applied to nursing students rather than all health professional undergraduates;
- in theory, under what the literature terms a Dedicated Education Model,[17] health services offering placements employ a clinical support person for student nursing placements. The charged fee reflects the health facility's costs, meaning the education provider pays the health service to deliver clinical support for their students on clinical placements. ANMF members have identified however that this can result in less access to nurse educators and the primary or even sole responsibility for the student

falls to clinicians on the floor, who have varying communication, clinical, and teaching skills, and who have to teach and support students while managing an unmodified patient work load;

- educators report difficulties in challenging or influencing the way clinical placements are being delivered – the limited numbers of placements compared to large numbers of students means health services have the 'upper hand', which allows them to dictate their expectations. While many health services are providing quality clinical placements, a tendency to prioritise service needs over education needs, has been reported to the ANMF.

Effective clinical support is an essential element to a quality-learning environment,[18] with undergraduate nursing students requiring access to preceptors, clinical support nurses and nurse educators[19] for timely clinical support from registered nurses who are equipped to support their learning and who are familiar with educational principles.[20]

The ANMAC mandated hours for clinical placement in a bachelor program is supported by the ANMF in terms of providing a safeguard for minimum hours. However, we consider there is room to improve the clinical experience of students. There are a number of Australian approved programs of study which provide more than the required 800 hours of clinical placement in their program, as they identify that 800 hours is insufficient. The minimum clinical hours in Australia for registered nurses are lower than those in other countries,[21] and our members advise that students would benefit from more clinical hours in the undergraduate program. The ANMF therefore recommends an increase in minimum clinical hours from 800 to 920 hours – the equivalent of an additional three weeks. Given the increased hours already provided by a number of universities, a minimum of 920 hours could obviously be accommodated without impacting on the theoretical component or program length. The ANMF contends that research is needed to explore the issues of quality and quantity of clinical placement hours in the bachelor program.

The need for clinical placement to occur in Australia

It is essential that the minimum clinical placement hours are completed in Australia. The ANMF recognises that there are benefits[22] in students experiencing health settings other than Australia, however, this needs to be seen as an adjunct to the Australian based minimum clinical placement hours.[23] Sending students overseas for clinical placements as part of their minimum hours without a structured support framework and not requiring the presence of an Australian registered nurse to support and supervise in, potentially, a health setting that may be substandard to Australia is not supported. The minimum clinical hours are essential to produce a registered nurse for the Australian context and therefore cannot be completed overseas. There should be a regulatory requirement to ensure that the mandated minimum hours are completed within the Australian context.

Clinical support

Supervision and support by experienced registered nurses are critical for a successful experience for nursing students while on clinical placements.[24] However, our members have expressed concern that at times there is no facilitator available to students. It is also essential that clinical facilitators/preceptors or buddies are experienced registered nurses who promote a positive learning culture, understand the importance of reflective practice and are able to provide appropriate constructive feedback from a profession specific perspective.

Many of our members also report that when their facility receives students for clinical placement, the facilitation of that placement impacts upon the quality of care because they are not adequately resourced to support the student and provide quality care. Supporting, supervising, mentoring, and training student nurses takes time and many nurses experience the additional responsibility as an "added extra".[25] The additional time required by registered nurses to meet their standards for practice through supporting student nurses on clinical placement must be taken into account in regard to the practice environment and the additional workloads imposed by managers and administrators when accepting students for placement.

Along with sufficient time, preceptors also need information. Education providers need to provide clear summaries of the student learnings to date to enable preceptors to understand the knowledge level they can expect from the student. As programs differ in delivery, milestone achievements relating to theory are not outlined for each year of a program. This can be confusing for preceptors and clinical education staff, creating unnecessary tension about expectations of students. The provision of simple, clear summaries would give clarity for all involved. A consistent assessment tool that is used across education providers would also assist both preceptors and clinical nurse educators in their role.

To address these issues it is essential that there is a quality support framework for students and the preceptor to access. This includes supernumerary clinical education support, when required, and clear documented outcomes for the clinical placement.

The *Best Practice Clinical Learning Environment Framework* (BPCLEF)[26] provides a comprehensive, evidence-based framework for support. This framework, as an established outcome based best practice principles document for clinical placement experience, could be required by ANMAC as a minimum expectation of providing appropriate clinical support via the accreditation standards.

Consistent with the ANMAC registered nurse and enrolled nurse accreditation standards, clinical facilitation and support must be provided by registered nurses, as opposed to enrolled nurses, given that the supervision and support of students of nursing is outside the scope of current enrolled nursing practice.

Service agreement

The service agreement is currently an essential policy lever to assist in improving clinical placement. Formal mechanisms between the education provider and health service are required to support dialogue, interaction and collaboration between the two parties. ANMAC accreditation standards currently require all education providers and health services to establish a contract. The ANMF recommends that this needs to be strengthened; the contract should clearly state the responsibilities of the education provider and that of the health service, including the model of clinical support being provided, the ratio of students to clinical nurse educator, the minimum qualifications of the nurse educator and a clear process for conflict resolution and/or escalating concerns.

Agreements between education providers and clinical placement providers should articulate how students will be mentored/preceptored and guided in their experience by a supervisory role undertaken by a registered nurse, including delegation and evaluation of care. The agreement needs to also strengthen the requirement for collaborative communication between the education providers and placement providers to promote continuity of the learning experience for the student as well as require annual evaluation designed to encourage open discussion between the two parties.

Sometimes these agreements, such as those relating to arrangements for professorial units or similar arrangements which combine academic and practice based education and research, extend beyond these parameters. These are supported by the ANMF and show strong connections between the health service environment and education environment. These partnerships are encouraged.

ANMAC should regularly review the collaboration between the education providers and health services, including service agreements and evaluations to ensure clinical placements are consistently being delivered as outlined in their approved curricula.

The ANMF suggests that the solution to improving the multitude of issues relating to clinical placements is twofold, by adjusting both the quantity and quality of the experience and implementing the following ANMF recommendations.

ANMF recommends:

That an evidence-based framework be identified in the ANMAC *Registered Nurse Accreditation Standards*, to provide a clear minimum requirement for support for undergraduate students on clinical placement, such as the *Best Practice Clinical Learning Environment Framework* (BPCLEF).

That the ANMAC *Registered Nurse Accreditation Standards* should require minimum clinical placement hours for the Bachelor of Nursing to be increased from 800 to 920 hours, an additional three weeks.

That ANMAC be funded to conduct independent research to explore the issues of quality and quantity of clinical placement hours in the bachelor program leading to registration as a registered nurse.

The current education preparation of registered nurses is effective at meeting the needs of health service delivery, and is producing capable and competent registered nurses who are meeting the health needs of the Australian community. The current Bachelor of Nursing provides a comprehensive generalist approach to education and is delivered in scholarly rigorous, research grounded universities. It is evidence based and clinically driven. The regulation for the program delivery is 'right touch' and ensures public safety. The ongoing quality improvement for programs is in place and needs to continue to ensure programs are meeting the needs of the profession and the Australian health needs into the future.

The ANMF recommends a number of improvements to be made in the current delivery of the program, as previously outlined, particularly relating to quality clinical placements. However, overall the programs are effective and they are meeting the needs of health service delivery.

Enrolled nurses

Current education preparation for enrolled nurses

An enrolled nurse is a person who has completed the educational preparation that meets the NMBA requirement for registration. The enrolled nurse provides nursing care, working under the direction and supervision of the registered nurse. Enrolled nurses are responsible and accountable for their own practice. The registered nurse is accountable for the delegation of care to the enrolled nurse and to ensure he or she monitors the outcome of that delegated care. Enrolled nurse are an integral and valued member of the nursing team.

Preparation for an enrolled nurse is a Diploma of Nursing that is delivered over 18 months in the Australian Vocational Education and Training (VET) sector. The program is delivered to meet the Australian Qualification Framework Level 5 and is a health training package, consisting of 20 core units and five electives.

The diploma provides a generalist approach, covering the application of theory and skills required for care delivery under supervision, across the health sector. It has a lifespan approach with competency achievements that relate to different stages of life and care requirements for each of 25 units. The development of the health training package for the Diploma of Nursing has strong stakeholder engagement at all levels and is reviewed regularly to ensure it is meeting the needs of the profession. The regular review also allows the program to remain relevant and keep up to date with the appropriate inclusion of national health priorities.

Currently, the theoretical and practical content is consistently taught across 58[27] programs approved to be delivered in Australia. It is nurse-led in its delivery and provides a skilful mix of evidence-based theory and practice. Registered nurses delivering the program are required to have relevant professional experience and education qualifications. The program has a minimum of 400 hours clinical placement.

What makes it effective?

The education for enrolled nurses is meeting the needs of the second level nurse. Enrolled nurses provide a valued contribution to the Australian health system. The registered nurse and enrolled nurse work together in complementary roles to provide the provision of safe, efficient and high quality nursing care across the varied health sector.

The two levels of nursing, one being educated in the higher education sector and the other in the VET sector augment each other in practice and the provision of care. Both skills sets are necessary to provide the level of quality care Australians expect. The two levels of education delivery for nursing enables an inclusive diverse population in the nursing profession. Social inclusion principles set out in 2010 by the federal government[28] were created specifically to ensure disadvantaged groups have the opportunities needed not only to work, but also to learn and to have a voice. The TAFE system, and more generally VET courses are crucial in allowing this to happen in the nursing profession.

There are a number of ways the VET sector provides for a strong recruitment pathway for many diverse Australians wanting to be a nurse. The VET sector permits the growth of the nursing workforce through provision of pathways into education. Becoming an enrolled nurse is often the next stepping-stone from a non-licensed health care worker such as an assistant in nursing (AIN) and is often the succession platform into

becoming a registered nurse. Many students have English as a second language and may not have the year 12 education level equivalent expected for university entrance. The VET sector allows and supports this group of people to increase their skills in Language, Literacy and Numeracy (LLN) via a pathway from Certificate III, to be eligible to apply for study of enrolled nursing and, if they are interested, ultimately the Bachelor of Nursing. Without this pathway of support, many students may never have had the opportunity to become a nurse and join the profession.

The VET sector also attracts funding from state and territory governments in the form of traineeships and apprenticeships, which does not occur in the higher education sector. The VET sector allows Australians to enter into qualifications that are an affordable first step. The sector enables students to continue to participate in employment whilst studying and achieving their qualification. The flexibility of study in the VET sector is attractive to those who wish to attain a qualification and continue to work to meet their living standards without acquiring large university fee debts.

Along with the access for diverse students enrolling into the diploma of nursing, the state and territories fund the VET sector, which enables local flexibility and responsiveness to workplace needs in a particular jurisdiction. There are a number of examples of this responsiveness occurring such as currently in Victoria where the State Government is fully funding the Diploma of Nursing to address the shortage of enrolled nurses in the state.[29]

Before the introduction of the NMBA, enrolled nursing minimum education varied across jurisdictions with some having a Certificate IV and others having a diploma. In 2010, the minimum education across the country became a Diploma of Nursing. The introduction of the National Registration and Accreditation Scheme (NRAS) has significantly benefited the enrolled nurse. It enabled national registration, meaning enrolled nurses can move and work across jurisdictions, and created a nationally consistent education platform.

National regulation also created a consistent approach to the delivery of education for enrolled nurses administering medicines. The NMBA, through the accreditation of programs leading to enrolled nursing, required all programs to educate enrolled nurses to be able to administer medications. Before this national approach there were inconsistencies in enrolled nurse scopes of practice, including education in the important area of medicines administration.

At this time, the NMBA also introduced a decision-making tool.[30] This is a key document, that assists registered nurses and enrolled nurses to understand how they augment each other's roles. It provides the regulatory requirements that were absent before 2010. The framework provides clear requirements for both levels of nursing regarding the supervision and delegation of care. The diploma uses these essential regulatory requirements to clearly educate enrolled nurses on their scope of practice and how they uniquely fit in the nursing profession to ensure public safety.

As outlined above, the current profession specific accreditation regulatory body is ANMAC, the national, independent accrediting authority, which ensures that diploma of nursing delivery is consistent with the accreditation standards. ANMAC also works closely with the Australian Skills Quality Authority (ASQA), the national vocational education and training regulator, to ensure diploma programs are meeting the requirements of the profession and the public. The dual regulators work hard to reduce duplication and enable continuous improvement in program content and delivery.

ANMAC outlines profession specific accreditation standards, which include minimum entry criteria for the program including base level literacy, numeracy and English language skills. These are essential to reduce the likelihood of admitting students who are unable to complete the program.

ANMAC's accreditation standards also require approved education providers to ensure the Diploma of Nursing students gain clinical experience in a variety of settings, from residential aged care to community environments, from rural placements to time in acute hospitals. When it works best, undergraduate education is a partnership between education providers and clinical facilities. These clinical hours are supported by experienced enrolled nurses who can role model and expert registered nurses who can teach and evaluate student performance while delivering quality care.

The features of current education that are problematic/missing- why and what's the solution?

Many of the concerns discussed in the registered nurse section about clinical placement also apply to enrolled nursing students. The issue of access and quality of clinical placements can be exacerbated further for enrolled nurses as education providers suggest that registered nurse students are sometimes prioritised over the enrolled nurse placement positions. Therefore, it is not uncommon for enrolled nurse placements to be provided only after registered nurse students have been given access.

Similarly to universities, education providers delivering the diploma have shared with the ANMF feeling powerless, and having 'fear of retribution' in the form of reduced placement access if they complain. The service agreement between the clinical placement provider and these education providers needs to be strengthened and to clearly state the responsibilities of the education provider and those of the health service. It should include the model of clinical support being provided, the ratio of students to clinical educator, the minimum qualifications of the clinical educator, and a clear process for conflict resolution and/or escalating concerns.

An evidence-based support framework should be identified in the ANMAC accreditation standards to provide clear minimum requirements for enrolled nurse students on clinical placements, such as the previously mentioned BPCLAF.

The ANMF also notes that although supportive of the current minimum 400 clinical placement hours for the diploma, we recommend that this is an area which would benefit from further Australian based research to confirm the amount of clinical hours and the clinical areas of exposure to continue to meet the needs of the profession and wider health service delivery.

ANMF recommends:

That an evidence-based framework be identified in the ANMAC *Enrolled Nurse Accreditation Standards*, to provide a clear minimum requirement for support for students on clinical placement, such as the *Best Practice Clinical Learning Environment Framework* (BPCLEF).

That ANMAC be funded to conduct independent research to explore the issues of quality and quantity of clinical placement hours in the Diploma of Nursing program leading to registration as an enrolled nurse.

Articulation

There are challenges in the articulation between the Diploma of Nursing and the Bachelor of Nursing. These challenges are two-fold: the first is that bachelor programs are unique, therefore requiring each to be separately mapped to the consistent diploma and secondly, the programs are delivered in two different education sectors. These challenges are, however, not insurmountable. The established difference between the two sectors enables the nursing profession, with the two levels of nursing, to work effectively and enables a clear and distinct scope of practice between the two levels. This difference can be celebrated rather than seen as a problem.

Although, there can be small challenges in articulation, recognition of prior learning is well established in both education sectors, which enables students to move reasonably easily between the two sectors. Further, many universities have already solved the challenge of articulation and have in place, agreed ANMAC accredited and NMBA approved entry pathways for enrolled nurses into the Bachelor of Nursing.

The current education preparation for the enrolled nurse is effective at meeting the needs of health service delivery in Australia. VET sector education providers are producing competent and capable enrolled nurses who work under the direct and indirect supervision and delegation of the registered nurse. The regulation of the Diploma of Nursing is 'right touch' and ensures students in the diploma programs meet the NMBA *Enrolled nurse standards for practice*. There are improvements to be gained in providing consistent quality clinical placements for enrolled nurses. This can be achieved by strengthening ongoing communication between the clinical placement provider and education provider. The ANMAC accreditation standards, requiring an evidence-based support framework to provide a clear minimum requirement for support for students on clinical placement such as the *Best Practice Clinical Learning Environment Framework* (BPCLEF), will assist in improving the quality of clinical placements. Future Australian based research on the quantity and quality of clinical placements for enrolled nurses would be beneficial to ensure future changes to the clinical placement structure in the diploma program are better informed.

There also needs to be improved communication between education providers, health service providers, and the NMBA. Many enrolled nurse members report that their employers prevent them from working to their full scope of enrolled nursing practice. This is often due to poor understanding by the employer of the current skills and competencies being gained in the Diploma of Nursing. This poor understanding is also exhibited where enrolled nurse members report the opposite scenario, that their employer is encouraging or directing them to undertake nursing practice that is outside the scope of enrolled nursing.

ANMF recommends:

That there is improved communication to employers, other health practitioners and the nursing profession by the NMBA and the VET sector regarding the practical skills, competencies, and scope of enrolled nursing practice

Nurse practitioners

Current education preparation for nurse practitioners

Nurse practitioners are Masters Degree prepared, experienced registered nurses who have the capability to provide high level clinically focused nursing care.[31] "The scope of practice of the nurse practitioner builds upon registered nurse practice, enabling nurse practitioners to autonomously and collaboratively manage complete episodes of care, including wellness-focused care, as an independent primary provider of care or as part of a collaborative team".[32]

The current masters program views advanced practice as a starting point and builds on the registered nurse's expertise for the autonomous role of a nurse practitioner, working in a specific area of practice or as a generalist. The program has a specialist approach to delivery with general content such as sciences that underpin all elements of practice and advanced holistic health assessment and diagnostics.[33] There is a requirement of 300 hours for clinical placement across the program. The masters program is delivered at an AQF level 9 in the University sector and programs are required to be accredited by ANMAC and approved by the NMBA. The program length varies across universities from 12 months to two years and is commonly delivered part time.

What makes it effective?

The education at a masters level is effective for nurse practitioners, who are well established in the Australian health setting as advanced clinical nurse leaders and whose benefits are recognised. They are providing safe, quality, competent, evidence-based care across all of the national health priority areas, and are crucial in meeting the growing needs and demands of Australia's healthcare system. Examples of nurse practitioners' contributions include:

- improving access to care though filling service gaps and supplementing traditional medical practitioner services, particularly in the primary care area;
- providing new and expanded services and new nurse-led models of care; and
- coordination of care across providers and sectors.

The nurse practitioner's scope of practice is reflective of their context of practice, where they are working and the education and expertise of the individual.[34] Nurse practitioners are found working in critical care, rural and remote areas, mental health, alcohol and other drugs, chronic disease management, primary health care, aged care and correctional services. They provide a value-based approach to patients, particularly in relation to costs and outcomes and to the healthcare system through nurse practitioner-led and collegiate models of care.

The pathway from a registered nurse to a nurse practitioner is clearly defined and the introduction of this level to the registered nurse career structure has allowed nurses to maintain a clinical presence while advancing their career, to the betterment of patients.

The educational preparation of nurse practitioners is supported by an effective and responsive regulatory environment, as with undergraduate nursing education. The NMBA registration standard for nurse practitioners provides clear regulatory requirements for achievement of endorsement as a nurse practitioner. Safety and quality guidelines for nurse practitioners produced by the NMBA provide clarity on the role and its delivery. These two documents and the ANMAC nurse practitioner accreditation standards for practice outline for education providers the regulatory end point of the required education for nurse practitioners.

ANMAC, as the independent profession specific accreditor delivers the profession specific regulation to the masters programs leading to registration as a nurse practitioner. The ANMAC accreditation standards for nurse practitioner provide the minimum requirements for the program, inclusive of the NMBA regulations. These standards enable universities to be innovative in their delivery. This approach is 'right touch' regulation for these high level programs. They need to be able to be flexible in their approach across varying speciality program content and delivery with mandated requirements.

The features of education that are problematic/missing- why and what's the solution?

Access to masters programs for nurse practitioners

The ANMAC accreditation standards outline the entry requirements for students into the masters program as a minimum of 'two years' full time equivalent as a registered nurse in a specified clinical field, two years of current advanced nursing practice in this same field,[35] and a relevant post graduate qualification. However, many education providers have additional demands such as students being required to have confirmed workplace support to complete the program, two identified clinical supervisors, and confirmed access to 300 hours of clinical placement. These extra requirements create a direct link between access to the masters program and employment opportunities for future nurse practitioners. Registered nurses who are interested in this path of education are unable to complete the course unless their workplace provides the opportunity.

Further, once students have gained the support of their workplace to complete the program there is no guarantee that a registered nurse studying in the program will gain employment as a nurse practitioner on completion. This may be due to either a lack of positions available, or the only nurse practitioner positions being already filled or there simply being no plans in place for nurse practitioners to be part of the workforce. ANMF members have advised us of this and suggest that some have even been asked to write a business case to have a nurse practitioner position created before they can begin studying and gain employment. The lack of nurse practitioner positions can result in internal 'turf wars' which risks promoting a culture of competitiveness as nurse practitioners are vying for limited positions.[36]

With Australia's growing population, ageing demographic and the changing nature of healthcare, workforce planning is vital to ensure the supply of nurse practitioners meets demand. Opportunities for nurse practitioners are currently solely driven by innovative workplaces rather than workforce planning. This needs to change. Governments need to identify potential workforce gaps through workforce planning projections and provide funding models that will sustain the employment of nurse practitioners in the workforce. This will provide governments, employers and higher education providers the opportunity to develop and implement plans to minimise workforce gaps, create innovative models of care and service delivery, and use nurse practitioners more widely and to their full scope of practice in both generalist and specialist contexts.[37]

Nurse practitioner employment opportunities are also affected by the promotion of the value of nurse practitioners in delivering effective and efficient healthcare services. Further work needs to address how nurse practitioners are valued. Along with effective workforce planning, if nurse practitioners are valued, positions will be created, universities will continue to offer post-graduate education for registered nurses to become nurse practitioners, and students will be able to access the program, having met the requirements for workplace support with genuine employment opportunities.

Effective and strategic workforce planning for nurse practitioners at the organisational, health service, and state and national levels is essential to overcome current limitations, and often, ad hoc processes.

ANMF recommends:

That federal, state, and territory governments offer financial incentives to health care providers to employ and utilise nurse practitioners in health services, with additional incentives to nurse practitioners who work in districts of workforce shortage.

National consistency in program delivery

Although the NMBA as the national regulator is well established to ensure public safety, there are inconsistencies in the scope of practice for nurse practitioners and therefore education program delivery. For example, in Victoria, nurse practitioners are required to prescribe medicines against a formulary under the Drugs and Poisons legislation and a notation endorsed by the NMBA. The consequences of the notation confines the nurse practitioner to a limited range of medicines to prescribe, even though the nurse practitioner can make an application for additional notations to expand the range of medicines to prescribe. All other states and territories are not limited by this restriction. This state based restriction should be removed to enable nurse practitioners to meet the future health care needs of the Australian community.

Program content focus

Consistent with the evolution of the role in North America, Australia's initial uptake of nurse practitioner roles emphasised a particular and specialised context of practice. This is supported by the ANMF, as it is appropriate for many nurse practitioner roles to be context specific, such as mental health, palliative care or wound care. The delivery of the current masters programs is effective in producing specialised nurse practitioners. Along with these roles, it is also important to expand the educational preparation for 'generalist' nurse practitioners. There is a small number of nurse practitioners currently working in these generalists roles, such as in emergency departments in an acute generalist role or a nurse practitioner working in primary care or aged care. It is critical that Australia continues to develop the numbers of both specialised and generalist nurse practitioner roles, particularly in primary health care, to continue to meet the needs of Australia's future health care delivery.

Funding/costs

The cost of studying to become a nurse practitioner is financed by the student. This, for some, is a barrier to undertaking further study. Financially supporting existing registered nurses to undertake study with scholarships or other financial incentives from governments, would be welcomed. Ideally, strategically focused employers should be identifying opportunities for the development of nurse practitioner roles to meet service needs and actively implementing clinician development programs to meet these needs.

ANMF recommends:

That federal, state, and territory governments provide additional funding for registered nurses to undertake the Masters of Nurse Practitioner programs leading to endorsement as a nurse practitioner.

Articulation

The articulation for a registered nurse to enter the masters program is clear. Along with the undergraduate program, nurses wishing to become a nurse practitioner are required to have completed a post graduate program in a clinical field at AQF level 7. Universities acknowledge the prior qualifications achieved by the registered nurse with the Bachelor and Post-graduate program completed.

As outlined earlier the registered nurses wishing to complete a masters program leading to endorsement as a nurse practitioner are currently also required by education providers to have support from their workplace. This is a barrier to nurses articulating into the masters programs and is preventing increasing the numbers of nurse practitioner graduates. Workforce planning and management is essential in addressing this articulation barrier.

SUMMARY

Australia's nursing education systems have been developed over six decades, including the creation of the enrolled nurse role in the 1950's. There have been articulation pathways since this second level of nursing was introduced; in the 1990's a pathway was established for registered nurses to articulate to the advanced practice role of nurse practitioner. The current nursing education systems and programs are more than adequately meeting the health needs of Australians. While there is room for improvement, and there have been some gaps identified, these are not significantly substantive, and can be remedied by the recommendations made above. As in all areas of health care, regular review of curricula and practice should be made with reference to evidence-based research, best practice, and adoption of innovative and successful approaches within Australian education institutions, and abroad, to accommodate future healthcare needs.

TERMS OF REFERENCE 2

Factors that affect the choice of nursing as an occupation, including for men

As the largest trade union in the country, the ANMF is well aware of the many factors that affect the choice of nursing as a career. These factors can be broadly categorised under the following themes: professional status, contribution to society as a whole, job security, working conditions and remuneration. These factors are of fundamental interest to the ANMF as we seek to address and improve them on a daily basis through both industrial and professional avenues. The following commentary expands on these factors, outlining how we can ensure they are attractive into the future for the successful recruitment of sufficient prospective nurses.

What do we know about the factors that affect the choice of nursing as a career?

There are currently many factors that will affect the choice of nursing as a career. These factors are presented below in six broad categories:

1. Professional status

Nursing is identified by the community as the most trusted profession and has been for many years. The Australian public identifies the nurse as a person who can be relied upon to protect and advocate for those for whom they care, and to provide them non-judgemental, compassionate and high quality care at a time of great vulnerability. This is an appealing feature which encourages many people to choose nursing as a career.

2. Contribution to society as a whole

A common phrase used by our members as the reason why they chose nursing as a career is 'they wanted to make a difference'. They want to help and care for people and their families in their time of vulnerability and need. These skills can also be used outside of work hours to help family, friends and their local community. These factors give nurses a strong sense of purpose and belonging and people considering nursing see how they can personally make a difference in this way.

Another important factor people consider as a positive for joining the profession is the opportunity to meet and care for a wide variety of people in Australia from all walks of life, all cultural backgrounds, all ages, all sexualities and all socio- economic backgrounds. Not many professions provide this opportunity.

3. Access and job security

Compared to other undergraduate programs for different professions, nursing programs are accessible. There are many nursing programs available across the country, at both bachelor and diploma levels. They are available in many locations, including opportunities for distance education if required. National registration has also enabled further flexibility with people being able to study long distance potentially in a different state to where they live but still be able to work in their home state or territory.

People considering a future profession want to be assured that they will have opportunities for employment after contributing so much time, effort, and financial impost to achieve their qualification. Nursing is known for having secure, long-term employment opportunities in the essential service of health.

4. Working conditions

The two levels of nurses, the registered nurse and enrolled nurse, provide choices for people, depending on their personal situation, career aspirations or financial accessibility to education.

Many people perceive nursing practice as rewarding and exciting work, as nurses work in a dynamic, changing health setting where practice is challenging and different on a daily basis. For some, this is an important element to their choice of career as they want to be challenged and have variations in their daily work, making interventions which can be life changing and lifesaving.

General working conditions for nurses are attractive factors to future nurses. With opportunities to work part-time, flexible hours of work and work in a highly unionised workforce is important to many.

Employment conditions are also important considerations: manageable workloads, access to continual professional development and attractive leave provisions are critical features of effective retention.

5. Career pathways and portability

The fact that nursing has a career pathway with classification structures to enhance progression as nurses gain further experience and education is appealing. Nursing has many opportunities for career development in a wide variety of clinical and non-clinical areas of work.

The nursing profession also offers significant portability. There are many different opportunities and places to work, such as working in a hospital, community centre, mental health unit, aged care facility, a school, in a local council, research, health policy, on a phone help line or even working using social media, both in Australia and overseas. Along with these varied areas of work, the location of available work is accessible and people understand that with nursing they can most commonly work close to home. There are also many opportunities to work in different speciality areas or context of practice. From working in an intensive care unit, to palliative care, mental health or academia.

6. Remuneration

Nursing is an attractive career to potential applicants as nursing positions overall have competitive salaries and there are many opportunities to increase one's salary with further experience and education. However, given the responsibility and accountability required of registered nurses, and subsequently nurse practitioners, remuneration is not competitive with other health professions with less or similar responsibility, accountability, and educational preparation. This is particularly the case in aged, primary and community care, even though these are the settings in most dire need of all three levels of nurse.

Why does it work?

Overall, nursing is an attractive career for people considering a new profession and even though there are a large number of education providers approved to deliver nursing programs, they are almost fully subscribed.

The data over the last few years has outlined that bachelor of nursing program commencements are increasing.[38] They show continual growth in the number of student commencements with 24,362 in 2017, an increase of 3% on the previous year. The number of commencements has increased by 36% since 2012. The number of applications for entry into the bachelor program has also significantly increased from 2011-2018 by 50.7%. The applications for 2018 were 36,517.[39] The diploma of nursing has shown a steady increase of student commencements over the last few years, although the 2017 data showed a small decrease of 4%.

What's missing, why and how can we improve it?

Recruitment and retention

Maintaining and improving the factors that affect the choice for nursing as a career are the responsibility of many, including nurses themselves, employers, education providers, governments and professional and industrial associations. Retention of the current workforce is an essential element in this responsibility and is required to continue to attract new people to the nursing profession.

The recruitment of new nurses and the retention of the current workforce go hand in hand. The numbers of new nurses joining the profession must continue to increase, to meet the demands of a growing, ageing population, with more co-morbidities, receiving increasingly complex health care. These changes, in combination with an ageing nursing workforce steadily heading to retirement, means that active recruitment into the profession in addition to the attracting factors described above, is essential.

Many of the factors that attract people to nursing also contribute to retaining nurses in the profession. Health service employers have a substantial influence, as do governments, on retention of nurses. Workplace conditions, manageable workloads, legislated nurse to patient ratios, fair and reasonable remuneration, career structures, safety and quality standards, and positive practice environments are all examples of factors which assist retention of nurses.

Another important factor of nurse retention has been identified as early career preparation, support and provision of opportunities, job satisfaction[40] and the opportunity for ongoing professional development opportunities. Supporting new graduates to transition to practice is critical to retaining nurses and ensuring a sustainable nursing workforce into the future.

When nurses are empowered to practice in accordance with the standards of the profession it increases work satisfaction and retention of the nursing workforce.[41] Job satisfaction is linked to opportunity and support,[42] effective, supportive and productive working relationships, access to education, effective clinical support and focused mentoring.[43]

The leadership and culture of an organisation also plays a central role in retention. Features of effective leadership include providing a motivational influence, being respectful and acting with integrity, role modelling, ability to resolve conflict, nurturing others by mentoring and coaching, developing staff by facilitating learning, and empowering staff.[44]

Working autonomously is important to many nurses, particularly those with experience. While there is potential for considerable autonomy for nurses, this is rarely realised outside the nurse practitioner role, and not always then; when combined with significant accountability, this can be a driver for people to leave the profession, or from care delivery roles.

Many of the negative aspects of the profession are, however, modifiable, providing doing so is seen and treated as a priority.

Attrition rates for nursing students

Nursing education programs are successfully recruiting and retaining enough students to meet current workforce demands. However, high attrition rates need to be addressed. For registered nursing students, the most recent workforce data showed a national average attrition rate of 34 percent, an increase of over 50 percent on the historical rate.[45] As no data has been released since 2012, there is currently no way to know if this was a statistical anomaly or a trend. In addition to no current data for registered nursing students, there is no information at all about attrition rates for enrolled nursing students. National data regarding nursing attrition rates needs to be collected and published, as recommended previously in this submission. Informed decisions about student intakes, and identifying and addressing barriers to program completion cannot be made unless this data is available.

Enhancing the image and valuing the profession

In Australia, nurses are consistently voted as the most, honest, ethical and trusted profession. Despite this, the profession of nursing continues to be undervalued as a whole. Nursing is largely female, and is portrayed as being more about caring than the therapeutic and scientific knowledge and skill that underpins nursing care. The public and our health professional colleagues need to be better informed about what nurses actually do. To improve their public image and to obtain a stronger position in healthcare organisations, nurses need to increase the visibility of the breadth, depth, complexity and scope of nursing practice.[46]

Appropriate remuneration

It is important that we ensure that nursing careers attract adequate remuneration and career advancement is sufficiently remunerated. Both employers and governments have a responsibility to ensure this occurs with particular attention required to address significant wage disparities that exist for nurses employed in aged, primary and community care.

Diversity

The section above has provided detail on the factors that affect the choice of nursing as an occupation, while identifying the relevance of retention. Along with this discussion it is important to consider the elements of diversity in the nursing population. The following outlines the current diversity of the nursing population, which ensures the profession is inclusive and has a broad range of practitioners to deliver care. A part of this analysis identifies the future work required to increase diversity in the student population and how students can be attracted into the nursing profession.

The available data on a number of diverse population elements is limited such as social and economic status of nurses. The ANMF, however, understands that the nursing population comes from a broad range of social and economic backgrounds. The two levels of nursing, that being registered nurse and enrolled nurse, facilitate this diverse mix of practitioners.

Sixty-three percent of nurses and midwives were born in Australia.[47] A high number of nurses are qualified in Australia: 77.9% of registered nurses and 94.2% of enrolled nurses.[48] The countries where the remaining nurses were qualified are varied.[49] Although the data on nurses who are a part of the Lesbian Gay Bisexual Transgender and Intersex community is limited, the 2016 Australian Census does provide data on same sex couples. It showed that the most common occupation for women in same sex couples is a registered nurse and the fourth most common occupation for men of same sex couples.[50] Data collection, accuracy and relevance, on the diversity of nurses needs further work, to ensure we are up to date with annual totals for future profession workforce planning.

There are two elements of diversity that the ANMF would like to explore further, including increasing the number of Aboriginal or Torres Strait Islander nurses into the profession and considering how men may find nursing more appealing.

Attracting and supporting Aboriginal and Torres Strait Islander Nurses

In 2015 only 0.9% of the 253,101 people employed as registered nurses, and only 2% of the 55,383 working as enrolled nurses in Australia, were Indigenous,[51] despite 3.3% of Australians identifying as being of Aboriginal or Torres Strait Islander heritage.[52] A major priority of the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM), which is strongly supported by the ANMF, is to develop and support recruitment and retention strategies for Aboriginal and/or Torres Strait Islander peoples in nursing. This need is particularly acute in remote areas, where reduced access to health care is caused by the same factors that inhibit participation as health care providers – distance, expense, and isolation.

Representation of Aboriginal and Torres Strait Islander nurses, along with supportive structures that make it easier for disadvantaged, rural, and remote candidates to undertake nursing qualifications (including clinical placements) will assist in making nursing a more attractive and achievable option for potential candidates. In addition, many of the strategies recommended for equalising the gender ration in nursing (see section below) will also improve inclusion across other demographics, including Aboriginal and Torres Strait Islander peoples.

ANMF recommends:

That federal, state and territory governments provide scholarships to support Aboriginal and Torres Strait Islander peoples to undertake nursing programs of study which lead to registration as a nurse or endorsement as a nurse practitioner.

That federal, state and territory governments collaborate with the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives (CATSINaM) to develop and expand initiatives that support Aboriginal and Torres Strait Islander peoples to undertake and complete nursing programs.

Nursing and gender

Despite movement toward gender balance in traditionally male professions, and multiple efforts to prioritise attracting men to nursing, Australia's nursing workforce is 88.9% female.[53] While this statistic has improved slightly over the last three decades, the low percentage of men in nursing in Australia remains broadly consistent with that across the developed world.[54] Factors that deter men entering, staying in, or recommending nursing as a career to other men include sexual stereotypes,[55] societal influences, perceived as a caring profession and discrimination,[56] and feelings of isolation.[57] An American survey of male nurses found 91% of respondents would recommend the career to other men, and reported that they entered or stayed in the profession for one of four main reasons: financial security or potential, either as a student (for example. scholarship opportunities, favourable tuition-to-earnings ratio) or post registration; career potential (diverse opportunities across fields, building on military or other previous health care experience, advanced practice nursing); job satisfaction (patient contact, active participation in care, seeing outcomes); or altruistic factors (desire to help people, personal/family experience as a patient, experience as a volunteer, contributing to society).[58]

Helpful strategies to encourage men into nursing have been identified by numerous sources. These include: support and education for family members and high school counsellors,[59] school visits by male nurses to talk to students,[60] marketing of courses in an androgynous manner,[61] additional qualifications that appeal to men,[62] careers fairs that do not specifically focus on female students,[63] involvement of men at career open days, recruitment campaigns directed specifically at men, and promoting technical and specialised areas of nursing.[64]

SUMMARY

This sector of the submission provided ANMF's insight into the factors that affect the choice of nursing as an occupation, these were broadly categorised under the following four themes: profession status, contribution to society as a whole, access and job security and working conditions. Retention was identified as a key element to continue to attract future nurses. The importance of attracting more Aboriginal and Torres Strait Islander nurses was highlighted, as was attracting an increase in men to the profession.

TERMS OF REFERENCE 3

The role and appropriateness of transition to practice programs however named

Transition programs for registered nurses and enrolled nurses

What do we do now?

Health services across the country deliver programs to support the employment and development of newly graduated nurses, both registered nurses and enrolled nurses. These programs are referred to as transition to practice programs (TPP's) or graduate programs. This section outlines the current role and appropriateness of these programs, highlighting the features of an effective program and providing future recommendations for transition programs.

As with undergraduate education, the transition period for nurse graduates is the shared responsibility of the education provider and the health sector employer. The education provider is required to produce the nurse graduate who has met the NMBA standards for practice and the health sector employer has to be 'graduate ready' and provide the support required to enable the graduate to effectively transition into practice. The graduate as a registered health practitioner is also responsible and accountable for practice within their professional requirements and limitations.

The TPP is an important program to support graduates who are experiencing a number of learning challenges in their first employment position as a registered nurse or enrolled nurse. Nursing graduates like all graduates of education programs are juggling many learning challenges and emotions in their first six to twelve months of practice. Graduates can experience issues of 'reality shock' and stress. They are becoming socialised to the health setting, while negotiating new relationships with many colleagues, adjusting to shift work and consolidating the skills they have learnt during the undergraduate program.

Transition to practice programs are offered in every state and territory, across a range of clinical settings that include public and private health services, aged care and primary health care. Public programs are variously government funded; with some funded through graduate and nurse education positions and others attracting specific funds per graduate employed, in some jurisdictions up to $16,000. Programs delivered in the private health setting are not government funded but are still seen to provide an important path for supporting newly graduating nurses.

Whilst welcoming the investment of government funding of TPP's, we note that the focus of these is commonly on supporting early career or graduate registered nurses to transition to practice. Additional planning and investment is required to ensure enrolled nursing graduates receive a similar level of support.

The role of any TPP must be to establish a supportive, positive framework within which nursing graduates can further develop their knowledge, skills and confidence as they move from student to a safe, competent beginning practitioner.

The content of programs varies across the country as does the health setting in which they are delivered. TPP's provide clinical support, which can include orientation, some supernumerary time, and access to a preceptor and nurse educator. Many include rotations, which may be across the service or, in some programs, across health sectors, such as rotations through the tertiary sector and primary health sector. Programs also include professional development opportunities for graduates, which usually focus on increasing theoretical knowledge and expanding or consolidating clinical skills that are specific to the graduate's practice setting.

The ANMF considers that more emphasis is required for clinical placements in primary health care settings. With a growing need for greater emphasis on early intervention and preventive care to counteract chronic diseases, primary health care placements will more adequately prepare nurses for the future.

ANMF recommends:

That federal, state and territory governments fund transition to practice programs for enrolled nurse graduates in acute, aged, primary, and community health settings.

What makes an effective transition?

The transition from student to registered practitioner is critical in maintaining and developing the nursing workforce and is rightly the subject of significant investment and planning in the healthcare sector.

Many newly graduating nurses obtain employment and experience a positive transition to practice. When a TPP is delivered well, it provides a supportive environment for graduates to thrive. In a positive learning environment graduate nurses are valued for achievements in completing the undergraduate program, their individual scope of practice and what they bring to the profession.

The Victorian Branch of the ANMF has recently worked with the Victorian Government to develop the *Nursing and Midwifery Transition to Practice Programs Guidelines 2018*.[65] These guidelines provide an evidence-based guide to support health services to provide an effective transition program. The guidelines align with the *Best Practice Clinical Learning Environment Framework* (BPCLEF) as identified earlier in the submission. The BPCLE Framework has been refined over ten years based upon stakeholder feedback. The Victorian guidelines are included as appendices to this submission and the ANMF supports their adoption as a national benchmark.[66] Importantly, this project also commissioned research into the views and experiences of graduates in relation to TPPs and provides valuable insight into their experiences.[67]

The ANMF considers the following features essential for a high quality TPP:

Flexibility

Health services should design and create programs tailored for their graduate, organisation and setting. For example it is possible for a small employer to provide high quality support to new graduates that is tailored to their setting and the individual needs of a graduate transitioning at their own pace. There is no single correct model for supporting a new graduate nor is there a single prescribed timeframe. However the underlying principles or elements articulated in the Victorian guidelines should be universally observed.

Strong nursing leadership

Strong, visible and accessible nursing leadership is critical in creating a positive learning environment, driving every element of high-quality transition to practice programs. Clinical and executive nursing leadership provides critical facilitation between the organisation and graduates, ensuring education is a priority. Nurses who take on leadership roles are instrumental in coaching and facilitating development of all TPP participants, and in the evaluation and continual improvement of the program.

Effective mentoring and preceptorship

According to graduate feedback in the Victorian research on transition, effective mentoring and preceptorship is vital.[68] Appropriately qualified and resourced nurse educators, clinical support nurses and preceptors (however titled) should be available to assist graduates, including the provision of one-on-one support or tailored learning opportunities. Organisations should maintain appropriate ratios of clinical educators and preceptors to ensure graduates have access to experienced staff who have realistic expectations of their individual and beginning level scope of practice. Formalised training should be provided to enhance the clinical leadership skills of staff members implementing the transitioning program.

Peer support

Support for graduates from all members of the health care team is essential. Graduate feedback indicates that feeling a valued part of the team and being provided with opportunities to learn from the staff they work alongside fosters a positive culture and new graduate experience.

Best practice clinical practice

An organisation delivering a TPP needs to model best practice behaviours, processes and practices to learners. The TPP should ensure that graduates and fellow team members understand the beginning scope of practice of each graduate. They need to acknowledge and understand just as with other nurses, newly graduating nurses have experience and skills in some areas of their practice and will need support in others.

Positive learning environment

Fostering a positive learning environment is crucial to effectively support new graduates. Key features of a positive learning environment include ensuring graduates feel valued, welcomed, and safe to report errors and ask questions.

Other essential features of TPP's include providing an orientation and induction to the work area; professional development for all members of the team in regard to effectively supporting graduates; providing graduates with scaffolded learning opportunities and facilitating incremental responsibility; providing targeted and constructive feedback; identifying learning needs; setting aside protected time for professional self-reflection and debriefing opportunities; and facilitating access to professional support as needed.

Understaffing and poor skill mix are not features of a positive learning environment. Peer support from members of the team is crucial to facilitate the development of confidence in the graduate. Excessive clinical workloads for both the graduate and preceptor prevent members of the team from spending quality time with graduates.

Effective communication and individualised support

Performance reviews and feedback to graduates are important mechanisms for the graduate to develop and reflect on their practice. Reviews provide the opportunity to identify areas of practice that are being delivered well by the graduate and areas that need further development. Regular scheduled reviews with preceptors and nurse educators is recommended and these should be anchored in a positive educational framework as opposed to a potentially punitive industrial framework.

ANMF recommends:

That an evidence-based framework for support be consistently applied across the country by federal, state and territory governments for all transition to practice programs, such as the *Victorian Nursing and Midwifery Transition to Practice Programs Guidelines 2018*.

What's missing and why does that matter? How can we improve graduate transition?

The ANMF contends that every early career nurse should be supported in the transition from undergraduate student to nurse. What is often not understood is that there is no regulatory requirement for graduates to have completed a formal TPP in order to gain employment. While a formal transition program is the ideal, there is considerable variation in these programs across sectors, ranging from a year long program in a public health facility to virtually nothing in, for example, a residential aged care facility. Lack of resources for a formal program should not be a deterrent to employing a newly graduated nurse. What is imperative is that the new graduate experiences an identified period of preceptored support in their transition phase (the duration determined between the employer and the graduate) into the workforce.

It is essential that employment opportunities for graduates are flexible to enable nurses to work the hours and locations that meet the needs of the nurse and their family. This flexibility also enables student intakes for undergraduate programs to be responsive to the large nursing workforce required and intakes therefore are not limited to the number of employment places following graduation. It also allows flexibility in the areas and locations where TPPs are delivered. This approach does however require close monitoring to ensure there are employment opportunities for all graduating nurses.

The ANMF has been working with stakeholders over many years monitoring the transition period for graduates. As employment of graduates is required to provide transition to practice support/programs, the ANMF understands the first essential priority for graduating nurses is quality employment and secondly, that they are provided with evidence-based appropriate support in the transition period. This will contribute to public safety and keeping graduating nurses working in the profession.

In 2014, there were escalating issues of unemployment for early career nurses. The ANMF estimated that 30-40% of nurse and midwife graduates in varying proportions across all states and territories had been unable to find secure employment over the previous three years.[69] In an attempt to address this significant issue the ANMF convened a National Graduate Nurse and Midwife Roundtable with key stakeholders to discuss and develop solutions to secure employment opportunities for these nurses and midwives.

The 2014 Roundtable was a successful event with over 30 leaders in nursing and midwifery and some federal politicians attending. Members included representation from the ANMF, NMBA, ANMAC, Chief Nursing and Midwifery Officers, Council of Deans, the Congress of Aboriginal and Torres Strait Islander Nurses and Midwives, the College of Midwives, public health sector nurses, aged care nurses and new graduate nurses. All participants at the roundtable agreed there was a significant problem of underemployment of newly graduating nurses and midwives, the causes of which were complex and varied. A working group was then established with four main objectives: improving the availability and quality of data, developing a document to debunk myths for early career nurses and midwives, identifying and undertaking required research, and then lobbying government armed with evidence for policy changes.

With secretariat support from the ANMF, the group has met regularly since 2014 to develop a number of key pieces of work to address the agreed objectives, to ultimately increase the number of employment opportunities for graduates. A second Roundtable was held in 2016, again with key stakeholders. The ANMF recognised that a collaborative approach from key stakeholders would be vital to the development and implementation of ongoing solutions to enhance national future employment for nurses and midwives. The 2016 Roundtable confirmed that although the concern of underemployment still requires close monitoring, the changes implemented since 2014, including state and territory governments significantly increasing TTP positions in a variety of health settings has stabilised the employment of graduates.

The Graduate working group has continued to meet regularly to keep a watching brief on graduate employment. Members agree it is essential that there is stakeholder discussion and engagement at the national level across health sectors to ensure graduate employment is closely monitored and to allow responses to any concerns. Although, there is a 12 – 18 month time delay in access to graduate data, the group understands difficulties in graduate employment are not uniform across the country and are frequently influenced by local jurisdictional factors. For example, currently there are underemployment issues for graduates in Western Australia. It is essential that workforce planning is addressed at a national level to ensure there are employment opportunities for graduates to support them in their transition to nursing practice.

Two documents were produced as a result of the Roundtable work: the *ANMF Graduate Data Set- Nurses and Midwives* and the *Facts and Myths Information Sheet*.

ANMF Graduate Data Set

One of the key areas of focus for the working group is accuracy of data related to graduates, in terms of numbers graduating, numbers registering and numbers then seeking work in nursing and midwifery. The group identified that no single organisation has exclusive carriage of monitoring and publicly producing

graduate nursing data. This information is essential to ensure a collective, nationally informed view of graduate employment and transition. The group developed and agreed on a data framework, which included five key questions to be addressed by the data:

1. Numbers of nursing and midwifery student commencements per year in a course leading to registration;
2. Numbers of nursing and midwifery course completions per year in a course leading to registration;
3. Numbers of new graduates registered (initial registration) from Australian Education providers in a one year period (AIHW data regarding first time registrations);
4. Numbers of new graduates (from those initially registered) from Australian education providers, employed in nursing and midwifery;
5. Number of graduate transition to practice places.

The ANMF has worked closely with the Department of Education and Training, National Centre for Vocational Education Research and the Australian Institute of Health and Welfare (AIHW) to analyse the data available using the agreed minimum data set as a framework. This data set was first developed in 2015 and has been updated every year since. The latest version of this data set can be found in Appendix 1 and is also publicly available on the ANMF federal office website.

The data set provides an informed picture of student commencements and completions for both the bachelor programs and diploma of nursing programs. It provides this national data over a number of years and then separates the data into states and territories. Initial registration with the NMBA for the two categories of nurse is also shown.

However, there are some limitations in the available data. Statistics are currently not available on the number of students per year and as identified earlier in the submission, attrition rates for programs. We also do not have a national understanding as to why students have chosen to leave or defer an undergraduate program. This is essential for making informed decisions on future requirements for a number of reasons including, ongoing development of ANMAC accreditation standards and monitoring plus planning for employment positions for newly graduating nurses.

The Australian Health Practitioner Regulation Agency (AHPRA) has the potential to provide insight on this data. AHPRA could potentially link the student registration data which is provided yearly by education providers to their registration number when the student has completed the program. However, AHPRA currently does not require students to complete an identification check at student registration level so the data cannot be linked to an ongoing registration number. If AHPRA's systems enabled student registration numbers to be linked to ongoing registration numbers the intelligence this would create would be invaluable. De-identified student data could be tracked from commencement in an undergraduate program and throughout their career. The data would be extremely useful not only in predicting graduate employment but also in wider workforce planning.

ANMF recommends:

That the Nursing and Midwifery Board of Australia (NMBA) add a question to the annual re-registration survey asking new registrants if they were provided with support and education during their first year of practice, and whether this was informal or a structured transition to practice program.

Facts and Myths – Information Sheet

The second piece of work the graduate working group completed was an information sheet on facts and myths regarding graduate employment and transition. The group of stakeholders identified that there were some cultural habits that sections of the nursing profession had developed over the years that needed to be addressed. These included some nurses having unrealistic expectations of graduates, not clearly understanding the current educational preparation for nurses, or the fact that there is no mandatory requirement for graduates to complete a TPP. It is essential that graduates of nursing programs are a respected part of the professions workforce who need support at the commencement of their careers. The fact sheet addresses these items and can be found in Appendix 2.

SUMMARY

The transition period for graduates can be a challenging time with graduates requiring sufficient support to ensure success. Both education providers and employers have responsibilities in promoting graduate transition. The education provider must ensure graduates are meeting the NMBA standards for practice and the employer must provide appropriate support through the transition period, to ensure public safety and keep graduates in the nursing profession. Many programs delivered are quality, supportive programs while others need improvement. The Victorian Nursing and Midwifery Transition to Practice Programs Guidelines 2018 provide an evidence-based guideline that should be implemented as a minimum standard across the country to provide more consistent quality in TPPs. Employment opportunities for graduates following the completion of their program need to be managed at both jurisdictional and national levels to ensure that graduates have quality employment to enable them to transition into practice.

TERMS OF REFERENCE 4

The competitiveness and attractiveness of Australian nursing qualifications across international contexts

INTRODUCTION

To assist in assessing the attractiveness of Australia's nursing education, the three primary nursing levels (registered nurse, enrolled nurse, nurse practitioner) have been benchmarked against the programs and frameworks of five other countries that are broadly comparable in socioeconomic, developmental, and societal expectation terms. These countries are: New Zealand (NZ), England, Canada, the United States (US), and Singapore – while the Philippines was considered, as their universities provide RNs tailored to an international market, both NP and EN roles are underutilised.

Having established where we are, this section then discusses current issues for new graduates and for the nursing workforce in Australia. This builds on the discussion in section two of this submission, regarding the attractiveness of nursing to potential candidates – recruitment is less of an issue for the long-term wellbeing of the population than retention, which is critical: we don't just need a workforce of safe, qualified nurses, we also need to ensure that graduate nurses have experienced mentors and colleagues, as patients need skilled, experienced nursing care.

This section continues by exploring the preparedness of Australia's nurses for the future of health care delivery, focusing on five, interconnected areas predicted to be most significant: aged care, chronic disease management, preventative health, primary health, and digital health.

Based on the combination of education trends and predictions here and in the countries Australia was benchmarked against, this section concludes with recommendations for both nursing education and as priorities for health departments on both national and state and territory levels.

International comparisons

Registered nurse

All benchmarked countries offer Bachelor of Nursing degrees, and facilitate articulation to these qualifications for enrolled nurse -equivalent applicants; similarly all the countries reviewed have a variety of entry points and/or shorter programs for applicants with a prior degree.

Like Australia, England, NZ and Singapore have fully transitioned to the tertiary sector for undergraduate registered nurse education. While Canada's other provinces have also transitioned to a bachelor's as the minimum requirement for registered nurse preparation, Quebec also provides baccalaureate and diploma programs as education pathways. The US similarly offers a variety of education options, from hospital-based vocational diplomas earned over two years, to associate degrees, and direct entry bachelor degrees that combine nursing coursework with general education units over four years direct entry (with some year-long programs completed in three years).

One of the key differences between the US and Australia is that the level of qualification, rather than the type of registration, determines the career avenues for registered nurses. Another significant difference is that a number of interventions which are part and parcel of registered nurse roles elsewhere have in the US become the domain of other health practitioners; most notable of these is the scope of respiratory technicians, who administer nebulisers, conduct percussive treatments, perform tracheostomy care, suction, and care for the ventilator requirements of intubated patients. These technicians are instead of, rather than in addition to, nurses.

Unsurprisingly, given the diversity of education programs, clinical hours requirements for undergraduate nursing students vary between states and provinces in North America. Compared with the other benchmarked countries, Australia's 800 hour minimum requirement is the lowest, followed by NZ (1100 hours), Singapore (1280 hours plus up to 400 hours to confirm clinical competence), and England (1530). It is noted that the Singapore Nursing Board (SNB) specifies in detail what type and how long the components of clinical placement must be; with SNB authorisation, up to 80 hours of placement hours may be replaced by the same amount of time in simulation.

Enrolled nurse (licensed vocational nurse, licensed practical nurse, registered practical nurse)

In the benchmarking countries, enrolled nurse (or regional equivalent) education programs range from 12 months (US) up to a three year diploma (Canada), with most courses conducted in the vocational education sector, running at a full-time equivalent period of 18-24 months.

England phased out enrolled nurse training from 1989, as part of the Nursing 2000 reforms, but has recently created an enrolled nurse-equivalent position (Nursing Associate) that has very similar education and scope of practice, to "bridge the skills gap between the roles of the unregulated healthcare assistant workforce and registered nurses."[70] The first graduates of the Foundational Degree program entered the workforce this year. Though registered with the Nursing and Midwifery Council, Nursing Associates do not have the same responsibilities as those enrolled nurses who continue to work in the system; for example, despite both groups being registered, only enrolled nurses are required to undertake continuing professional education to maintain registration, and may work in positions as high as the equivalent of Australia's associate charge nurse.

Australia is the jurisdiction with the lowest mandated minimum pre-registration clinical hours at 400, followed by England (460 hours), NZ (900), and then Singapore (1120); again, both Canada and the US have requirements that vary widely between provinces/states.

For all countries the scope of practice is broadly similar, with Singaporean enrolled nurses having the most limited scope regarding medication administration (restricted to subcutaneous insulin, topical creams, eye/ear/nasal drops, nebulisers, enemas and suppositories only), while in Alberta registered practice nurses have almost the same scope as registered nurses; in some US states enrolled nurses may provide care for ventilated patients.

Nurse practitioner (advanced practice nurse)

England's advanced nurse practitioner role does not currently require Masters level preparation, though "there is a consensus among the UK health departments that Masters level education will be expected in the future,"[71] and it is a mandatory component of being credentialed as an ANP by the Royal College of Nursing.[72]

The other comparison countries have nurse practitioner (titled 'advance practice nurse' in Singapore) pathways with consistent education and experience requirements: in all cases the baseline requirement is a Masters-level nursing qualification and significant clinical expertise – on average, over a decade of pre-Masters experience.

Nurse practitioners in Canada, New Zealand, and the US have broader levels of practice than Australia's advanced clinicians; Canadian nurse practitioners have a broad scope of practice that includes issuing of death certificates, and inclusion in Canada's Medical Assistance in Dying legislation, enables them to function as both evaluating practitioners and administrators of the medications that facilitate easier dying for qualifying terminally ill people.

The US first introduced nurse practitioners in 1960, and now has over 270,000, 87% working in primary care (vs only 8% of medical graduates). In 23 states and Washington, DC, nurse practitioners have full authority to practice independently - they can assess, evaluate, diagnose, and manage treatment (including ordering and managing medications); in 15 states, nurse practitioners have reduced practice authority that requires a regulated collaboration agreement with a physician; and in 12 states, nurse practitioners have restricted practice authority that necessitates supervision, delegation, or team management by a physician. Note that a number of US universities are replacing their nurse practitioner -oriented Masters programs with doctoral courses.

Singapore requires registered nurses to have at least five years clinical experience (including three years+ in the relevant area) or at least two years' experience and an advanced diploma, and the Masters program includes 1200 hours of acute adult medical/surgical clinical practice placement; after completion of formal education, applicants are issued a provisional advanced practice nurse licence and must perform a one year internship with their sponsoring institution (under medical mentorship), then pass an exam before achieving APN certification.

New Zealand established the role of and pathway to nurse practitioner in 2001, and nurse practitioners are now an integral part of the NZ health care system. They have a wider scope of practice than their Australian colleagues - in addition to General Medical Service (equivalent to MBS) subsidies, and the same prescribing authority as medical practitioners (within their scope and specialty), they may issue sick and death certificates, and Te Kaunihera Tapuhi o Aotearoa/Nursing Council of NZ has determined that "newly registered nurse practitioners will no longer be restricted by a condition stating a specific area of practice,"[73] to facilitate workforce flexibility.

SUMMARY

While the primary aim of nursing education is, rightly, to meet the healthcare and workforce needs of Australia, consideration should also be given to whether both our programs and our graduates are internationally competitive and attractive. The benchmarking discussed above demonstrates that the current models of education for all three levels of nursing practice are consistent with or exceed the requirements of those in the comparison countries in sector positioning and type and length of program.

Australia continues to attract large numbers of international students to nursing education programs, demonstrating that these programs are attractive and competitive on an international level. Additionally, it is considered a 'rite of passage' for many of our early career nurses to spend a period of time working overseas. That they are generally able to both achieve registration with relative ease and then work within different health systems without significant (often any) additional education or experience, illustrates that nursing education in Australia continues to reflect emerging evidence and best practice.

However, the current minimum clinical placement requirements for both enrolled and registered nursing students are significantly lower than elsewhere. In section two of this submission the ANMF recommended that the number of clinical placement minimum hours for registered nurses should be increased to 920 hours. This recommendation would bring registered nurse education more closely in line with the requirements of other countries.

While a number of the comparison countries have substantially longer periods of clinical placement, it is important to note that more time alone does not necessarily equate to better preparedness. Among the factors that affect the effectiveness of quality clinical placement are the location, the level of engagement with students by the facility, the type of support students have from both their education provider and clinicians, and how 'student ready' workplaces are.

This last aspect has not been well explored in the literature around undergraduate clinical placement, with much more emphasis placed on the readiness of students and early-career nurses for work. However, there are far too many stories of clinicians discovering they've been allocated to mentor a student as the student arrives, of students' clinical experiences involving pairing with multiple nurses, and of nurses being too busy to explain or teach.

It is essential that education providers and health care facilities work in partnership to ensure that student nurses have quality clinical placements as outlined in section 2. The ANMF has recommended that this could be improved by ANMAC introducing an evidence-based framework for quality placements for all three nurse levels of education.

AREAS OF FUTURE FOCUS

The following section provides elements for the future focus for nurses' work, considering the effectiveness of educational preparedness for registered nurses, enrolled nurses and nurse practitioners. It identifies a number of health priorities that will require expansion of nursing care and thus both theory and clinical practice education programs. This expansion will require nursing education to continue to adapt content as appropriate to ensure the education of nursing keeps pace with Australia's future healthcare needs.

Aged care

Australia, along with the rest of the developed world, has an ageing population – the Australian Bureau of Statistics (ABS) predicts that within 25 years there will be a median increase in age of 1-3.6 years, from 37.2 in 2017 to 39.3, and as high as 40.7 by 2066.[74] This shift is largely attributable to a projection of almost twice as many people aged 65 or over, including double the number of Australians aged over 84, an increase (factoring in population growth modelling) from the current level of 2% to 3% of the total population.[75]

While ageing is not synonymous with disability or disease, living longer increases the likelihood of developing chronic illnesses - at present, 80% of Australians over 65 have four or more chronic conditions.[76] The success of modern medicine means that we are not only living longer, many of us are doing so with multiple health issues, including behavioural and mental health concerns,[77] and this rate is increasing.[78]

Chronic illness is particularly prevalent in people who have dementia. People with dementia have complex care needs as a result of having a degenerative disease that affects cognitive, emotional and physical function; people with dementia have an average of two to eight concomitant health conditions,[79] and 90% of people with dementia have at least one comorbidity,[80] a higher incidence than age-matched people without dementia.[81]

In 2016 it was estimated that over 400,000 persons with dementia were living in Australia. The prevalence of dementia is projected to increase by 90% by 2037, with a 2.75 fold increase (to almost 1.2 million people) by 2056.[82] People with dementia represent just over half of all residents in residential facilities and they tend to have much higher care needs than residents who do not have dementia.[83]

This increase in both life expectancy and rates of chronic disease will correspond to higher demand for aged care services, both in community and residential placement. As illustrated by the Royal Commission into Aged Care (in progress), this is a sector that is struggling with consumer cost, access, service equity, and delivery of appropriate, quality care; and the issues are magnified in regional and remote areas.

This combination of increasing health complexity and the physical fragility that often accompanies advancing age means higher need for skilled nursing care, and therefore a workforce able to meet both the requirements of providing that care and the increasing numbers of people in need of clinical care, both in their homes and living in residential care facilities.

There are approximately 900 residential aged care providers and approximately 2,500 residential facilities operating in Australia. There are minimal structured career opportunities within aged care for nurses, meaning career recognition and development is ad hoc and dependent on the policy and operations of each provider. There is already an identified shortage of aged care workers. In 2017 there were an estimated 94,672 paid care workers looking after people with dementia in the residential aged care setting. It is projected that by 2036 173,225 care workers will be needed in the paid care accommodation sector.[84]

Older people have complex care needs, an increased risk of pharmaceutical interactions and side effects, a higher incidence of organ dysfunction, and greater vulnerability to accidents and infection than most people, requiring frequent evaluation and assessment in addition to the provision of fundamental care and condition-specific nursing care. Despite this, the predominance of care delivered by aged care support services is provided by assistants in nursing (variously titled), a role that has no minimum education entry requirement; the most common education undertaken is a Certificate III in Aged Care, which incorporates no education around dementia as part of the core or elective units.[85] This lack of training in dementia care has an impact on the quality of care, meaning opportunity for the best outcome is sometimes lost, deterioration and complications may go unnoticed, and sub-optimal care is provided in some instances.[86]

All aspects of aged care (including nutrition, hydration, oral care, hygiene, wound care and health care in general) can be and often are more complex to manage for people with dementia. While many of the tasks themselves do not require significant skill, education, or expertise to perform, assessment and evaluation of need and delivery of care very often require all three components. For example, the symptoms of dementia mean other health issues may be masked, difficult to detect, and difficult for people with dementia to communicate.[87] This increases the risk of both preventable complications[88] and missed or inadequate treatment for other health issues. Risks around providing medication may also be increased due to the effects of dementia.[89]

As submissions and statements to the Royal Commission into Aged Care have clearly demonstrated, this is an under-served population with increasingly complex medico-pharmacological needs. Despite the Australian Medical Association's 2017 Aged Care Survey Report[90] demonstrating a rising demand in both number of residents and need for health practitioner attendance, there are fewer nurses employed in aged care, and fewer GPs prepared to service this sector. In contrast, whilst nurse practitioners are both willing, and able, to provide safe, efficient, quality primary care to the ageing community, their role remains underutilised.

For some time aged care has been seen by some, both inside and outside the nursing profession, as not as prestigious or valued compared to other sectors. In reality it is a multifaceted specialty area that requires expertise, education, experience, and a significant suite of skills to effectively, efficiently, and safely deliver care to a cohort of the population that is particularly frail, vulnerable, and at high risk of complications from all aspects – pharmacological (higher incidence of side-effects and interactions), nurse-sensitive adverse events (for example, urinary tract infections, chest infection, pressure injuries), acute deterioration and general decline (from worsening chronic conditions and/or additional acute illnesses), and accidents (falls in particular).

We need to continue to prepare nurses of the future for this sector, through education and destigmatisation. While attractors (like the introduction of carer: resident ratios, skill mix, and pay parity) are beyond the remit of this Review, re- evaluating the importance of this changing sector in each pre-registration program, with an emphasis on the rewards of the sector and the potential for career progression, combined with an option for additional aged care placements (allowing students to appreciate the complex nature of the specialty, rather than focusing on the performance of foundational care) will increase the attractiveness of working in this area.

ANMF recommends:

That the undergraduate program re-evaluate the importance of educating students about the provision of aged care, emphasising the skill and expertise needed to provide safe, quality care to this population.

Chronic health management

It is not only the aged care sector that has seen an increase in the prevalence of chronic condition. As in the rest of the developed world, Australia has a growing segment of the population living with at least one, and often more, chronic diseases.[91] This is problematic for several reasons, including reduced capacity for work (paid, unpaid or volunteer), reduced ability to fully participate in life, lower quality of life, truncated length of life, and financial burden to both individuals and the community as a whole.

Chronic diseases are more commonly the cause of, or a contributing factor to, presentations to emergency departments and admissions to hospital than acute illness, and therefore account for a large proportion of nursing time and care delivery.

Some chronic diseases are relatively static, with intermittent exacerbations; others begin as an acute illness and either take months to years before a return to pre-morbid health or never fully resolve, and many chronic conditions have episodic peaks and troughs of health and function within an overall trajectory towards incapacity and morbidity. In all cases the aims of therapy are to reduce severity of the acute phases, maximise function and wellbeing, reduce the frequency and severity of complications and exacerbations, and initiate end-of-life planning well in advance of need.

In very many cases the health practitioner best placed to provide education, support, care, evaluation, and assessment is a nurse. This may be at the bed side, in follow up outpatient appointments, by a general practice nurse in a clinic, or by a nurse practitioner. Regular health review and monitoring, detection and treatment of deterioration or acute worsening, evaluation and assessment of interventions, and care planning to reduce or avoid exacerbations are key to improving quality of life.

Encouraging more registered nurses to work in general practice nurse roles, and to transition to qualify and work as nurse practitioners in community health and chronic disease management, will significantly contribute to lightening the burden chronic disease has on individuals, their families, and the wider community. Government, work places, and universities should create partnerships that facilitate the entry of appropriate candidates to general practice nursing post-graduate qualifications and to masters programs leading to nurse practitioner qualification, through the provision of scholarships, improved remuneration, peer support, mentorship, and promotion of the roles of nurses and nurse practitioners working in general practice settings.

Preventative health

Health promotion and preventative health care are intertwined approaches to reducing the rate and severity of reducible health conditions. Both modalities are aimed at individuals and communities, but the former is about providing education, engagement, and empowerment to encourage healthier choices and make positive

life style changes (for example, smoking cessation initiatives, the five-a-day campaign to increase vegetable and fruit intake), and the latter targets preventing specific diseases (such as, immunisation schedules, testing kits to screen over 50s for bowel cancer).

A 2009 report predicted that the combination of increasing tobacco-related taxes and smoking cessation education would reduce the prevalence of smoking by 10% and prevent over 248,000 premature deaths by 2020, at a cost of $276 million, for a savings over $5 billion in health care costs alone.[92]

Yet despite figures like these, and research demonstrating that almost a third of health care expenditure is directed at conditions that have one or more modifiable components (for example, tobacco and/or alcohol misuse, physical inactivity, hypertension, elevated cholesterol levels, low consumption of fruits and vegetables, and increasing BMI), only 2% of Australia's health care budget is directed toward preventative health.[93]

Nurses and nursing education need to be driving forces to change the emphasis in Australian health care for managing acute and chronic disease to prevention and promotion of healthier life choices.

Digital health

The digital revolution (which includes the widespread adoption of technologies) has converged with health, health care, the way we live our lives, and society at large. This intersection between technology and health has been incorporated into the planning, performance, monitoring, documentation, and evaluation of health care, as well as more individualised aspects of health care delivery, such as improving the precision and personalisation of medication.[94]

Digital health has the potential to, and is, improving efficiency of the health care system in general, and the effectiveness of intervention, through a multitude of methods. We are at the beginning of the digital health age, and it is difficult to predict many of the innovations that lie ahead. It is essential that the nurses of the future, including those who are learning now, have the tools and skills to adapt to and be involved with the range of emerging and yet-to-be-imagined health technologies.

These gains do not come without a cost, and while the financial impost will often pay off in terms of reduced ongoing health care requirements and the burden of managing complications and errors, there are other risks associated with the growing digitalisation of health care. Key among these is the risk to privacy and vulnerability of technology to hacking, which may occur as data breaches and harvesting or as hijacking of health care monitoring and delivery systems. As the largest component of health care practitioners, nurses should be identified stakeholders in understanding these risks, working within safeguards, and contributing to risk analysis and development of solutions, as well as identifying areas for future development.

Digital health needs to continue to have a strong emphasis in undergraduate programs, enabling nursing students to understand the theory and practical application in a simulated setting as well as a real-life health care setting. As digital health evolves it is important for education providers and ANMAC to continually evaluate its impact on health and how nurses should be educated to meet the needs of health care delivery.

Clinical Supervision

Clinical supervision is an evolving area to support education effectiveness for nurses. It is a method of professional support and learning which provides a space for reflection on practice and work issues, which may be impacting on the supervisee. It aids the development of practice through regular discussion time with colleagues and may be undertaken in a 1:1 or group environment. The supervisor will be an educated, knowledgeable and experienced practitioner.[95]

The purpose of clinical supervision is: to provide a safe and confidential environment that allows nurses to reflect on and discuss their work and their personal and professional responses to this work. Reflection supports nurses and aids in their personal and professional development as they reflect on their practice.[96] To improve nursing practice, it needs to be focused on nurse-patient interaction[97] and to facilitate the professional development of the supervisee(s) through increased awareness and understanding of the complex human issues within their workplace.[98]

Clinical supervision provides an opportunity for nurses to: reflect on and review their practice, discuss individual cases in depth and change or modify their practice and identify training and continuing professional development needs.[99]

The benefits of clinical supervision include:

- improved quality of care and services, lower sickness rates, improved recruitment and retention, better work culture, improved morale/job satisfaction, improved risk management,[100]
- peer support, increased staff effectiveness, stress relief, the promotion of professional development and accountability, the development of skill and knowledge,[101]
- improved role satisfaction for both the supervisor and supervisee,
- playing a key role in contributing to self-care and personal empowerment through reflective practice in a supportive and safe environment,[102]
- providing an environment where staff can explore their own personal and emotional reactions to their work,[103]
- allowing staff to reflect on and challenge their own practice,[104]
- contributing towards meeting requirements of professional bodies and regulatory requirements for continuing professional development,[105]
- being linked to good clinical governance, by helping to support quality improvement, managing risks, and by increasing accountability.[106]

The benefits of clinical supervision are clear. Education providers and health settings should embed clinical supervision in the undergraduate program, post-graduate nursing programs and the masters program leading to registration of nurse practitioners. Although, not in the remit for this review, all nurses employed should also have access to clinical supervision.

ANMF recommends:

That all nurses have access to clinical supervision as a continuous professional development strategy for providing ongoing learning, support and self-care.

That education about the principles of clinical supervision be embedded in all nursing undergraduate and vocational education.

CONCLUSION

In this submission the ANMF has demonstrated that the current systems in place for educating registered nurses, enrolled nurses, and nurse practitioners are robust, evidence-based, and produce clinicians who are able to meet the health care needs of Australia's population.

Utilising both the vocational and higher education sectors to deliver content for different levels of nursing increases the accessibility of entering the profession to students who may be deterred from undertaking a degree. Diploma of Nursing programs don't neatly map against the early part of nursing degrees. Despite this, universities are having no difficulty recognising this prior learning when enrolled nurses undertake degree programs, thus facilitating articulation between the qualifications and across the education sectors. The ANMF have made several recommendations regarding the quality of clinical placements, as well as research into the optimum number of placement hours to balance immersion and the development of clinical competence with feasibility and placement site availability. We have also noted that, in the absence of data regarding student attrition, there is no way to identify the factors that contribute to failure to complete, where students exit education programs, or how to address these factors.

Nursing is an attractive profession for many reasons, but has had little success in substantially increasing the number of male graduates; the literature indicates that this is primarily due to the continuing emphasis of care in media depictions of nursing, without inclusion of the complex, interconnected and evidence-based foundations underpinning the delivery of care. Aboriginal and Torres Strait Islander peoples are becoming better represented in nursing, but recruiting and retaining Indigenous nurses needs support and attention.

While transition to practice programs (TPPs) are the ideal way for early career nurses to safely consolidate their pre-registration education and experience, at the same time as expanding and refining their practice, we do not believe such programs should be a mandatory requirement, as this would unduly burden smaller and rural health care providers, and reduce graduate flexibility. Our discussion and recommendations instead centre on consistency in delivery, funding, and expanding the clinical areas where TPPs are offered to aged, primary, and community care.

Benchmarking the type and length of comparative education programs against five countries of similar development, socioeconomic status, and population expectations of health care showed that Australia is on par with, and in some cases exceeds, international practices for both pre-registration education and nurse practitioner preparation. This submission has also identified five key areas of future focus that nursing education must continue to incorporate into curricula to continue to meet the nation's evolving health care needs.

The ANMF appreciates the opportunity to contribute to this important review, and look forward to the report.

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APPENDICES

Appendix 1 –Australian Nursing and Midwifery Federation (2019). *ANMF graduate data set: nurses and midwives.* Melbourne: ANMF

Appendix 2 - Australian Nursing and Midwifery Federation (2018). *Facts and Myths Information Sheet.* Melbourne: ANMF

APPENDIX 1

ANMF Graduate Data Set - Nurses and Midwives

June 2019

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CONTENTS

INTRODUCTION

In 2014 the Australian Nursing and Midwifery Federation (ANMF) established a National Graduate Nurse and Midwife Roundtable which brought together over 30 nursing and midwifery leaders and key industry stakeholders to discuss ways of securing employment opportunities for nursing and midwifery graduates. The Roundtable included representatives of the Council of Chief Nursing and Midwifery Officers, the Nursing and Midwifery Board of Australia, the Council of Deans of Nursing and Midwifery, the Congress of Aboriginal and Torres Strait Islander Nurse and Midwives, the Australian College of Midwives, federal politicians, public sector and aged care employers, nurse educators, a number of professional nursing associations and, of course, new graduates themselves.

All participants agreed there was a significant problem of underemployment of nurse and midwife graduates, the causes of which are complex and varied, and that further work, which focuses on addressing the key causes, was required. Subsequently, a Working Group of interested Roundtable participants was formed to undertake this further work.

One of the key areas of focus for the Working Group has been ensuring the accuracy of data related to graduates, in terms of numbers graduating, numbers registering and numbers then seeking work in nursing and midwifery. After much discussion and review of the current available data, the group developed and agreed on a minimum data set that is required to make informed predictions and outcomes for future graduate employment.

Five main questions were posed, these included:

1. Numbers of nursing and midwifery student commencements per year in a course leading to registration.
2. Numbers of nursing and midwifery course completions per year in a course leading to registration.
3. Number of new graduates registered (initial registration) from Australian Education providers in a one year period (AIHW data regarding first time registrations).
4. Of the new graduates (initial registration) from Australian Universities, how many are employed in nursing and midwifery.
5. Number of graduate transition places.

The ANMF then worked closely with the Department of Education and Training, National Centre for Vocational Education Research and the Australian Institute of Health and Welfare (AIHW) to drill down on the current available data using the agreed minimum data set as a framework. The ANMF also sent correspondence on behalf of the Graduate Working Group to, 131 large aged care providers and private hospitals across the country and all Chief Nursing and Midwifery Officers in each state and territory requesting potential transition/graduate positions for nurses and midwives for 2016. The following data booklet has been developed and updated from this completed work, to clearly identify what data is available, what remains outstanding and the limitations with some of the available data.

Limitations

The ANMF has some concerns about of the accuracy of data available and presented within the document in terms of providing a complete data set related to graduate nurse and midwife employment. This is primarily due to the ANMF's inability to gain access to some portions of relevant data. These concerns are identified as limitations and notes throughout the document.

GRADUATE DATA SET

1. Numbers of nursing and midwifery student commencements per year in a course leading to registration:

Data Item	Available/ Unavailable	Location/Status
Registered Nurse & Midwives	✓	Table 1.1
Registered Nurse	✓	
Midwife	✓	Table 1.3
Enrolled Nurse	✓	Table 4.1

Data divided into:

Aboriginal and Torres Strait Islander Nurses and Midwives	✓	Tables 1.5-1.6 & 4.1-4.4
State and Territory	✓	Tables 1.2, 1.4 & 4.2
Course title – divided into two categories: - Higher Education straight Bachelor and - Double Degree	 ✓ ×	 Not available
International cohort – visa type	✓ ✓	RNs & midwives Tables 1.1-1.4 ENs Tables 4.1-4.4

2. Numbers of nursing and midwifery course completions per year in a course leading to registration as a:

Data Item	Available/ Unavailable	Location/Status
Registered Nurse & Midwives	✓	Table 2.1
Registered Nurse	✓	
Midwife	✓	Table 2.3
Enrolled Nurse	✓	Table 5.1-5.4

Data divided into:

Aboriginal and Torres Strait Islander Nurses and Midwives	✓	Table 2.5-2.6 & 5.1-5.2
State and Territory	✓	Tables 2.2, 2.4 & 5.1
Course title – divided into two categories: - Higher Education straight Bachelor and - Double Degree	 ✓ ×	 Not available
International cohort – visa type	✓ ✓	RNs & midwives Tables 2.1-2.4 ENs Tables 5.1-5.4

3. Number of new graduates registered (initial registration) from Australian Education providers in a one year period (NHWDS requested data re first time registrations)

Data Item	Available/ Unavailable	Location/Status
Registered Nurse	✓	Table 6.3
Midwife	✓	Table 6.5
Enrolled Nurse	✓	Table 6.7

Data divided into:

Aboriginal and Torres Strait Islander Nurses and Midwives	✓	Tables 9.1-9.8 & 10.1-10.4
State and Territory	✓	Tables 8.2-8.36
Course title – divided into two categories: - Higher Education straight Bachelor and - Double Degree	✓ ×	Not available
International cohort – visa type	✓	485 - Temporary graduate 457 - Temporary work

4. Of the new graduates (initial registration) from Australian Universities, how many are employed in nursing and midwifery?

Data Item	Available/ Unavailable	Location/Status
Registered Nurse	✓	Tables 7.4, 7.5 & 7.6
Midwife	✓	Tables 7.10, 7.11 & 7.12
Enrolled Nurse	✓	Tables 7.7, 7.8 & 7.9

Data divided into:

Aboriginal and Torres Strait Islander Nurses and Midwives	✓	Tables 8.1-8.36
State and Territory	✓	Tables 7.1-7.3 & 8.2-9, 8.11-8.18, 8.20-8.27, 8.29-8.36
International cohort – visa type	✓	Tables 9.1-9.4
Full-time/part-time- hours per week	✓	Tables 8.1-8.36
Public sector		Tables 8.1-8.36
Private sector		Tables 8.1-8.36
Aged Care sector (not a sector but available in Principal area and work setting)	✓	Tables 10.1-10.4
Other		
Principal area	✓	Tables 10.1-10.4
Principal work setting: • If working part-time how many are actively looking for full-time work? • If not working in nursing and midwifery, what occupation are they employed in?	×	Not available

5. Number of graduate transition places

a. Divided into:		
State and territory		
Public sector	✓	Table 11.1 Note: Table not updated with latest data
Private sector	×	Insufficient data to report
Aged care sector	×	Insufficient data to report
Part-time/ full-time- hours per week	×	
Principal area	×	
Principal work setting	×	
Number of employers offering structured transition programs	×	
Number of employers using a state or territory based recruitment tool, such as computer match for recruitment.	×	

DATA SOURCE & NOTES

TABLES 1.1 to 3.2 Student commencements in a course leading to initial registration Number of commencements (Tables 1.5-1.8) and completions (Table 2.5) for indigenous and non-indigenous students Number of completions for initial registration Total student enrolments for initial registration	ANMF data request to Department of Education and Training, Higher Education Statistics Collection **Notes:** Separation of Registered Nurse and Midwife data in Student commencement and completion tables requires further information re how Universities report this. Data is available by 'field of education" ie "Midwifery" but further clarification is required on interpreting this information
TABLES 4.1 to 5.4 Enrolled Nurse enrolments (commencement program) – All training activity (2014 and 2017) Includes fee for service VET by community educators and private providers Enrolled Nurse completions – All training activity (2014 and 2015)	National Centre for Vocational Education Research (NCVER) 2017, Australian vocational education and training statistics: total VET students and courses 2017 - data tables, NCVER, Adelaide. https://www.ncver.edu.au/research-and-statistics/collections/students-and-courses-collection/total-vet-students-and-courses **Notes re Tables 4.1 to 5.2:** Data in relation to "All training activity" including non-government programs, not available prior to 2014
TABLES 6.1 to 9.8 Initial Registration data – covers numbers registering for first time (based on registration ID numbers) Includes workforce status and employment data for RN, MW and EN nationally and by State/Territory	ANMF data request to Health Workforce Division Department of Health Data extracted from National Health Workforce Dataset, Nurses and Midwives 2013, 2014, 2015, 2016, 2017 Combination of registration and survey data collected at time of registration renewal **Notes:** NHWDS initial registration data was used as AHPRA graduate nurse data is unavailable Part 6 Numbers re First time registration by country of qualification contains high numbers of "Not stated" or "inadequately described" Part 7 Workforce data re First time registrations includes domestic and overseas graduates. It excludes non-respondents Part 10 First time registration data by indigenous status and visa type contains high numbers of not stated or inadequately described responses For full details relating to this dataset provided by NHWDS refer to Notes on page 104

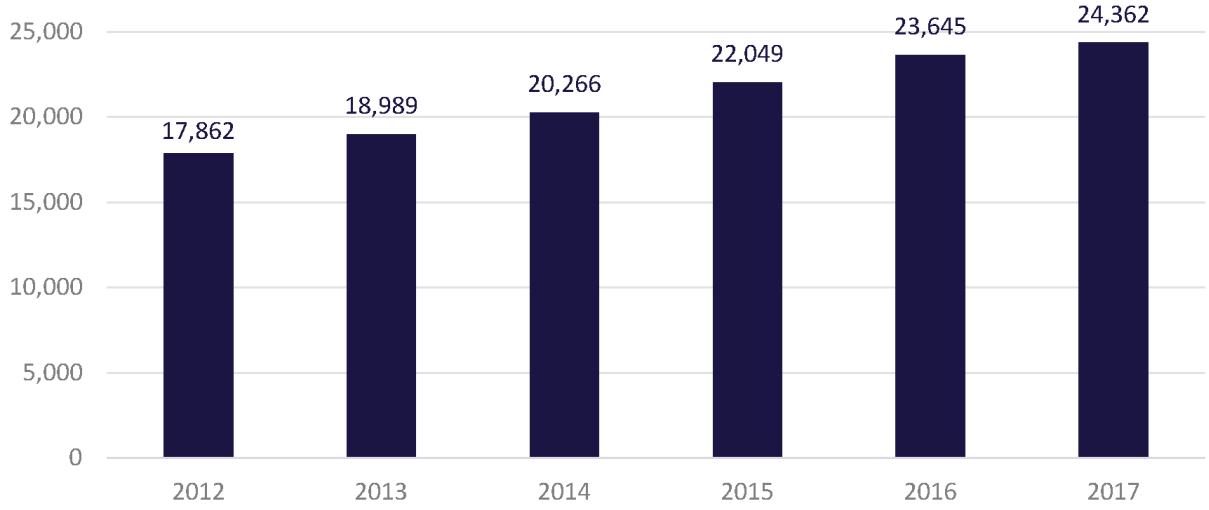
NATIONAL NURSES AND MIDWIVES DATA OVERVIEW

REGISTERED NURSE AND MIDWIFE DATA:

Undergraduate student commencements per year in a course leading to registration 2012 to 2017*

- The data shows continual growth in the number of student commencements with 24,362 in 2017, an increase of 3% on the previous year. The number of commencements have increased by 36% since 2012.
- There has been little change in the relative share of commencements by citizenship over the 2012 - 2017 period with Australian citizens making up almost 80% of student commencements; students on Temporary entry permits 15%; permanent residents 4 to 5%, and New Zealand citizens, other overseas and permanent humanitarian visa holders making up less than 0.5% respectively.

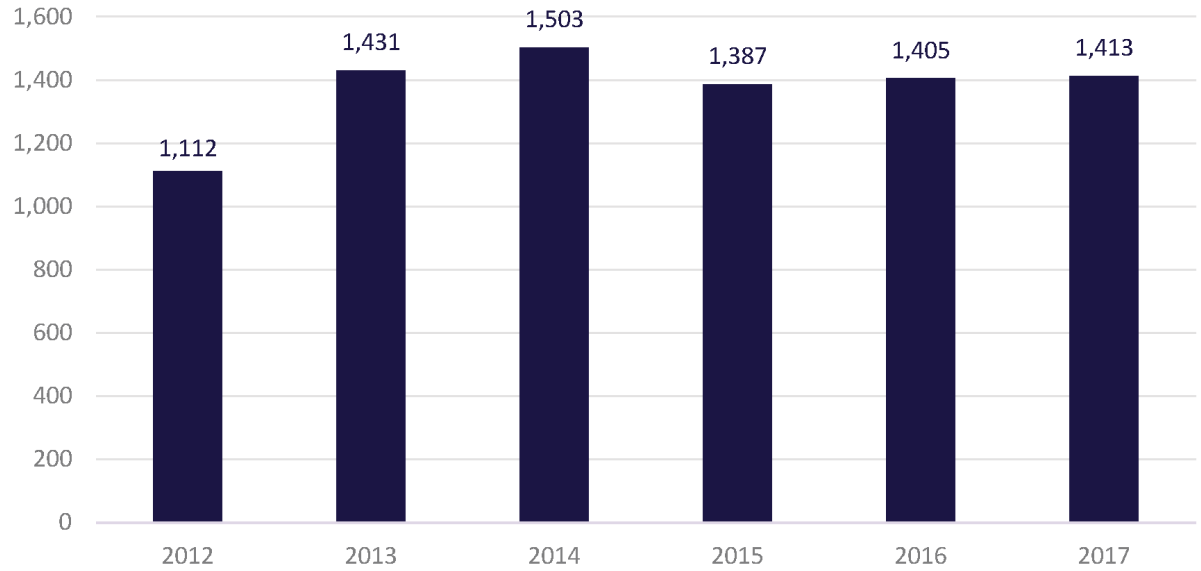
Number of commencements for initial registration as a nurse, 2012-2017



Midwifery data (Direct Entry Midwives)

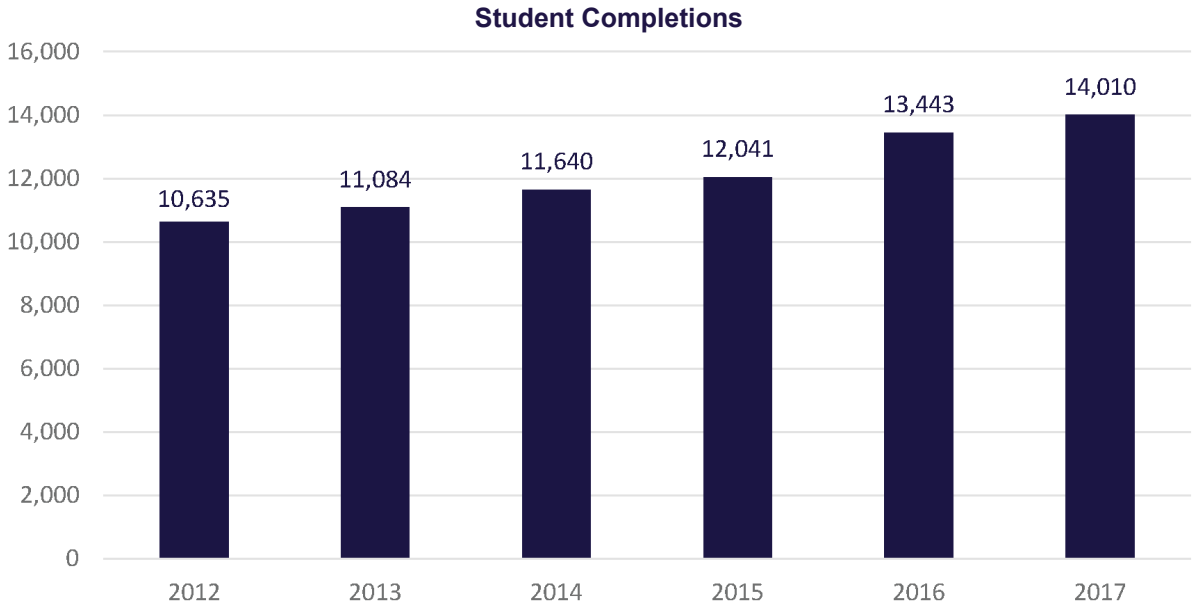
- Overall, midwifery commencements have increased by 27% since 2012 however since 2015 there has been little change.
- In 2017 Australian citizens made up 86% of student commencements in midwifery and is reasonably consistent with previous years.

Midwifery data extracted from: Number of commencement by detailed field of education and citizenship - Bachelor's Pass, Bachelor's Graduate entry & Bachelor's Honours numbers



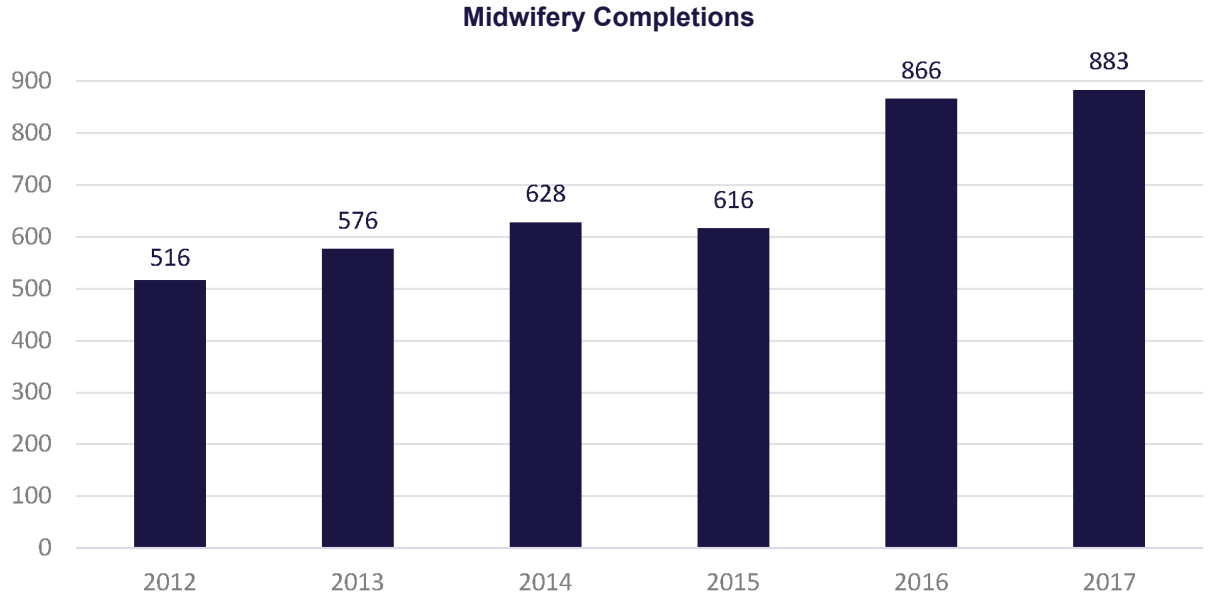
Undergraduate student completions per year in a course leading to registration 2012 to 2017*

- Student completions over this period have increased by 32% from 10,635 in 2012 to 14,010 completions in 2017. Between 2015 and 2017, completions increased by 16%. This compares with more modest increases of 3.4% and 5% in previous years.
- Australian citizens accounted for 77% of completions in 2017. This figure is consistent across the 2012 to 2017 period. There has been little change in the relative share of course completions for other categories of citizenship except for holders of temporary entry permits which shows a decline from 19% in 2012 to 17% in 2017.



Midwifery data (Direct Entry Midwives)

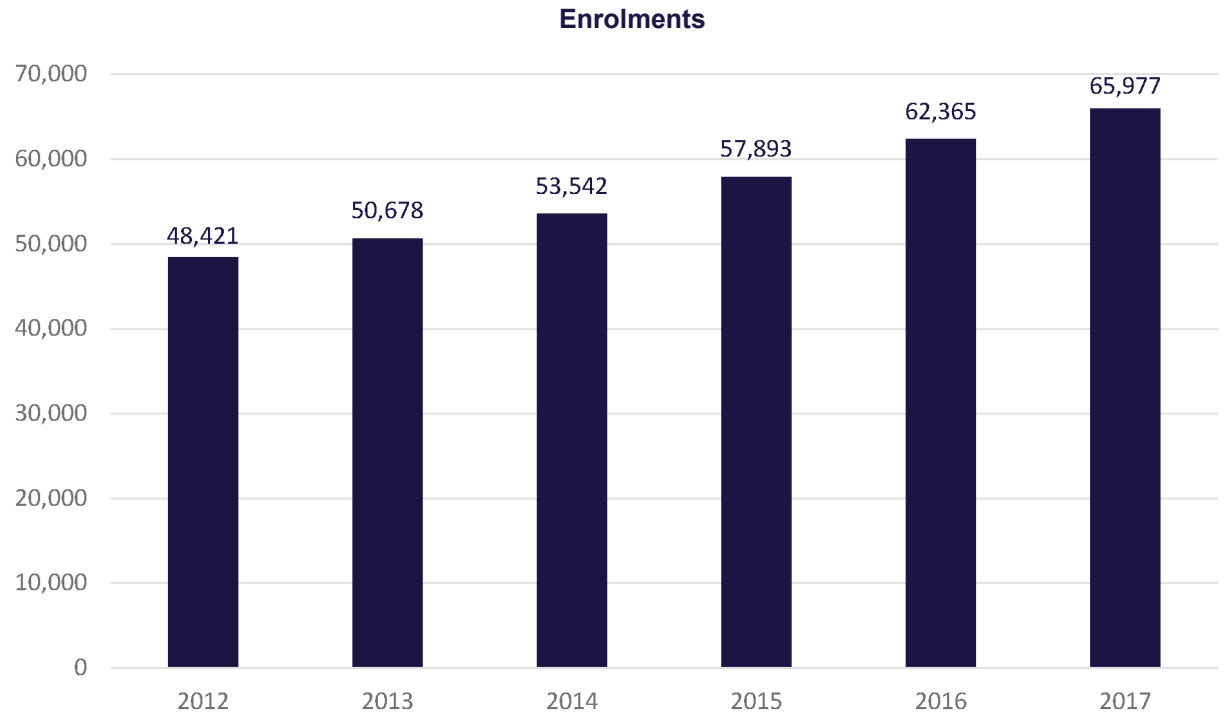
- Between 2012 and 2015, there was a gradual increase in the number of midwifery course completions. The figure increased sharply in 2016, with a similar number of completions in 2017.



* Programs leading to registration as a registered nurse or midwife

Total enrolments for undergraduate nursing and midwifery programs*

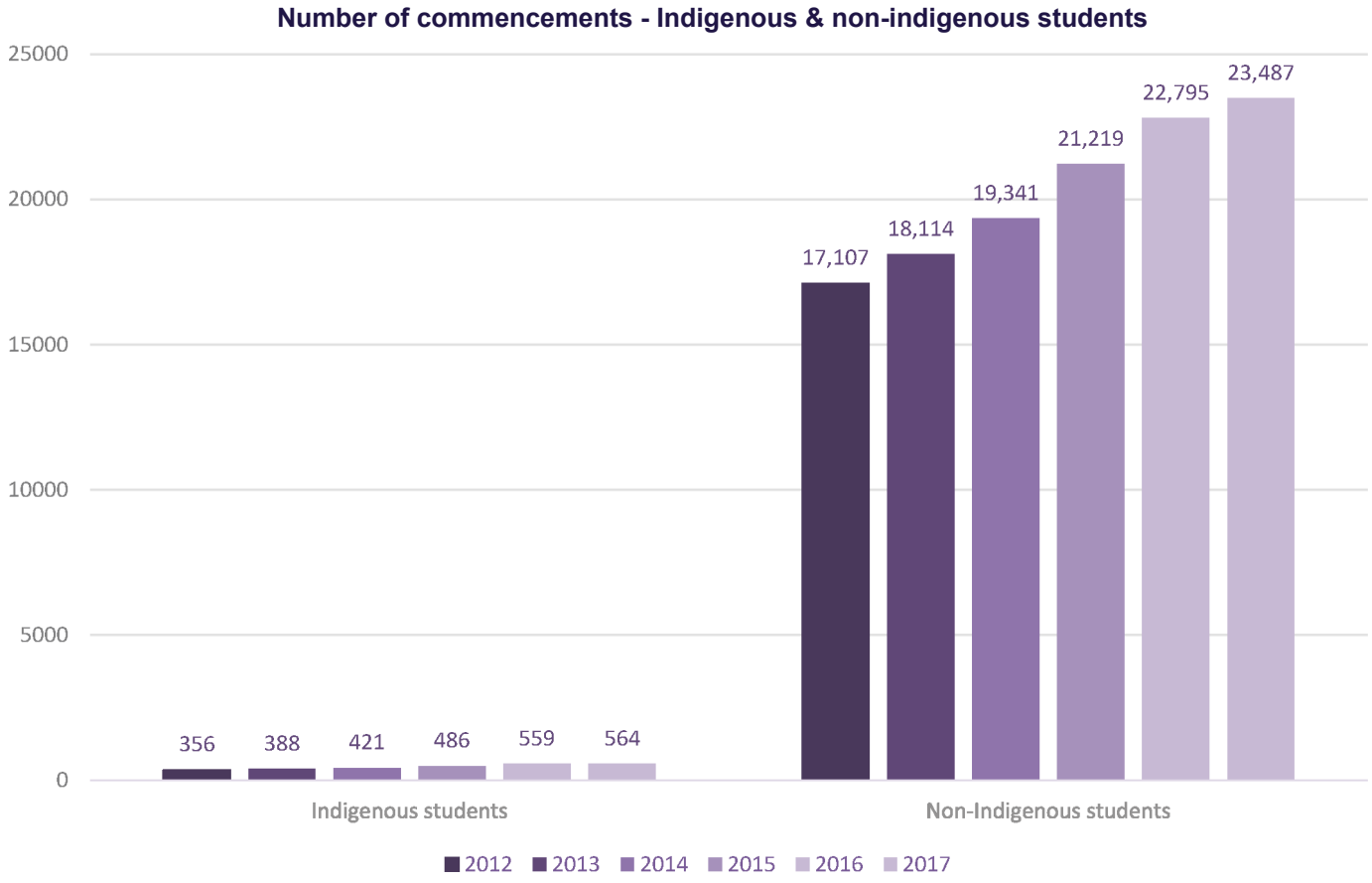
- Total enrolment numbers for 2017 were 65,977, an increase of 36% since 2012 with overall enrolments at 48,421. Enrolments are up 5.8% since 2016 - lower than the 7.7% growth between 2015 and 2016.
- Australian citizens made up 81% of enrolments at 2017, consistent with previous years. Similarly, the percentage share of students who are permanent residents and those holding temporary entry permits have remained relatively stable over this period.



* Programs leading to registration as a registered nurse or midwife

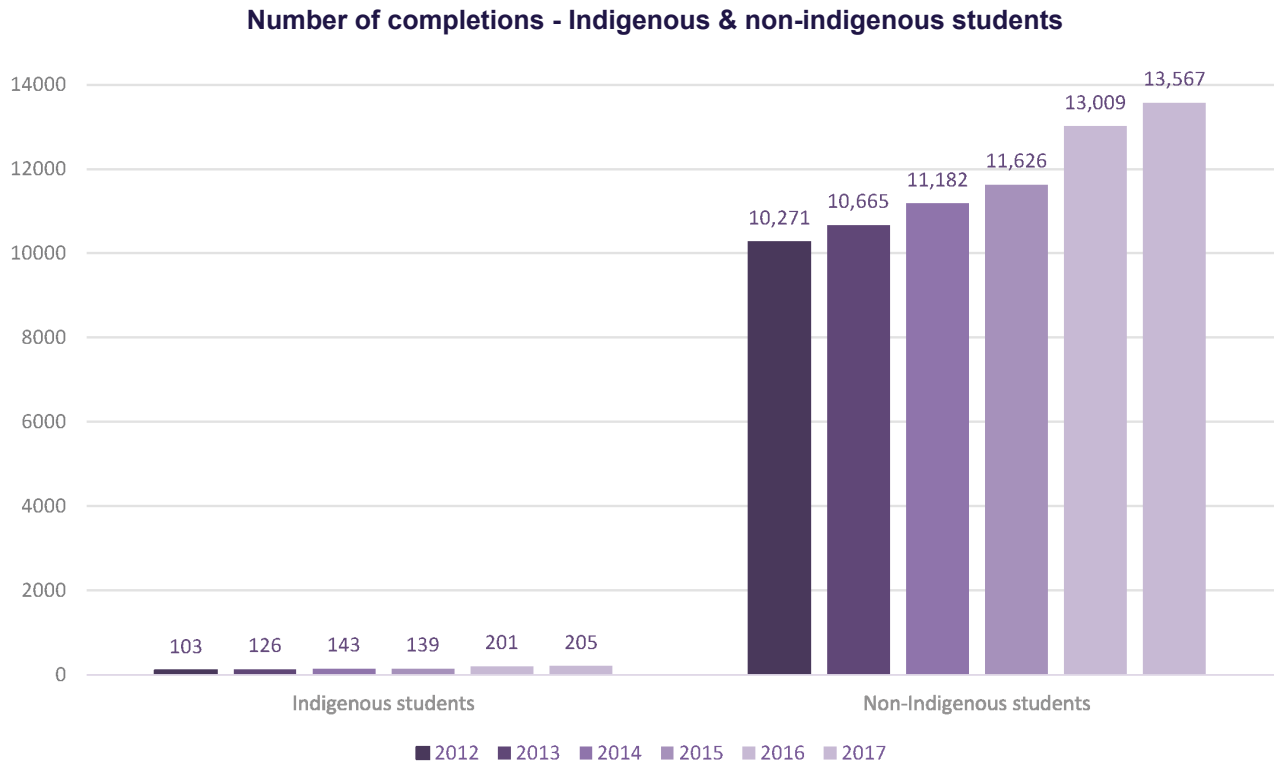
Number of commencements for undergraduate nursing and midwifery programs - Indigenous & non-indigenous students

- The number of course commencements for indigenous students have increased from 356 in 2012 to 564 in 2017, but overall, indigenous students made up just 2.3% of total student commencements in 2017, similar to 2016.



Number of completions for undergraduate nursing and midwifery programs - Indigenous & non-indigenous students

- 205 indigenous students completed courses in 2017 compared to 103 in 2012, doubling the number of completions. In 2017, there was a small increase in the number of indigenous student course completions from the previous year.

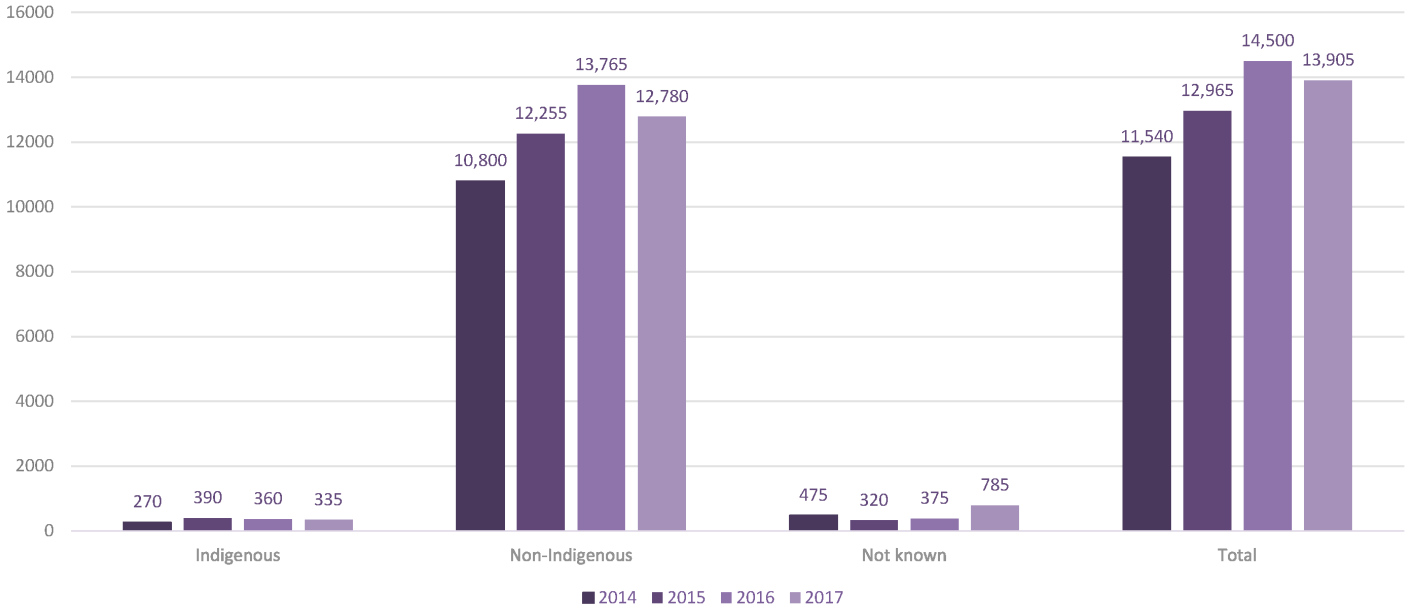


ENROLLED NURSE DATA:

Enrolled nurse - commencements

- In 2017 there were 13,905 enrolled nurse commencements, a 4% decrease from 2016 figures.
- Enrolments for both indigenous and non-indigenous students decreased by 7% from 2016 to 2017.

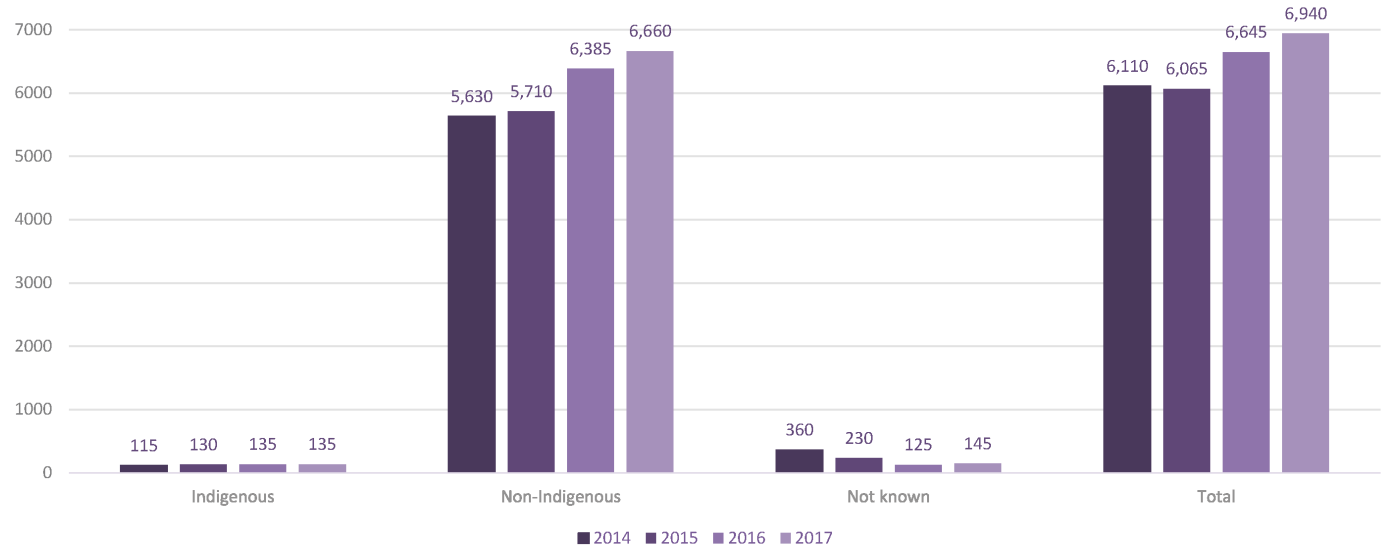
Enrolled nurse commencements



Enrolled nurse - completions

- Completions increased by 4.4% in 2017, continuing a positive trend since a decrease between 2014 and 2015.
- There were 135 completions by indigenous students in 2017, a small increase from 2016. The number of non-indigenous student completions increased 4.3% in 2017.

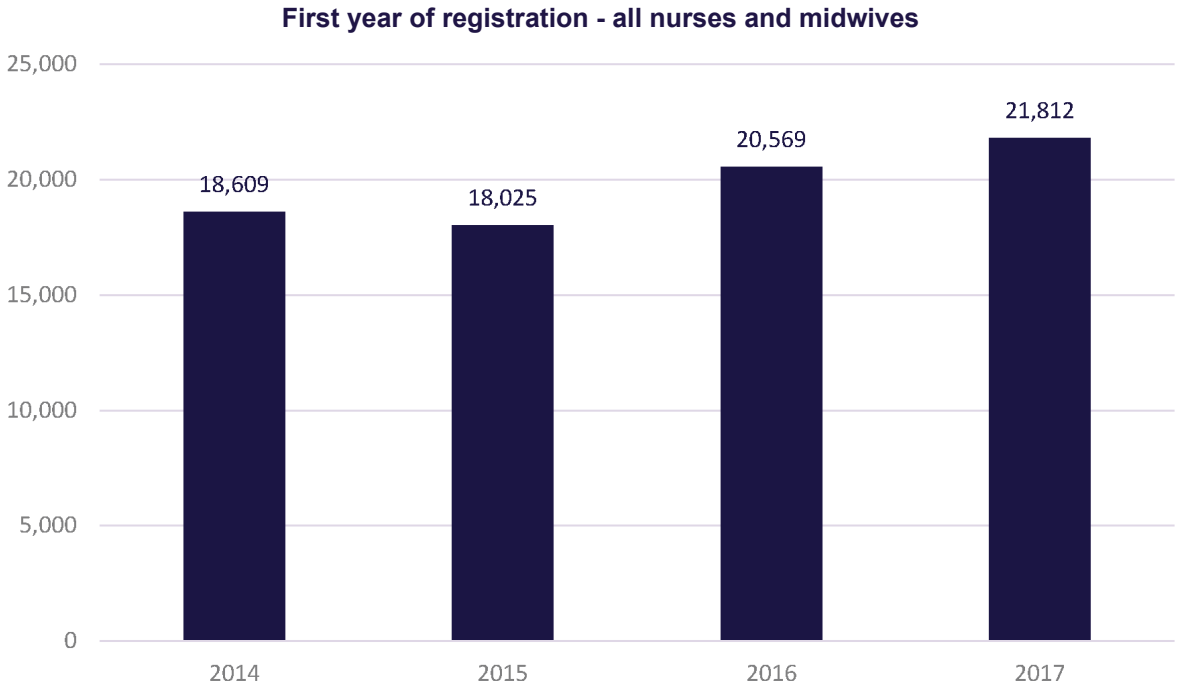
Enrolled nurse program completions



NHWDS FIRST TIME REGISTRATION DATA:

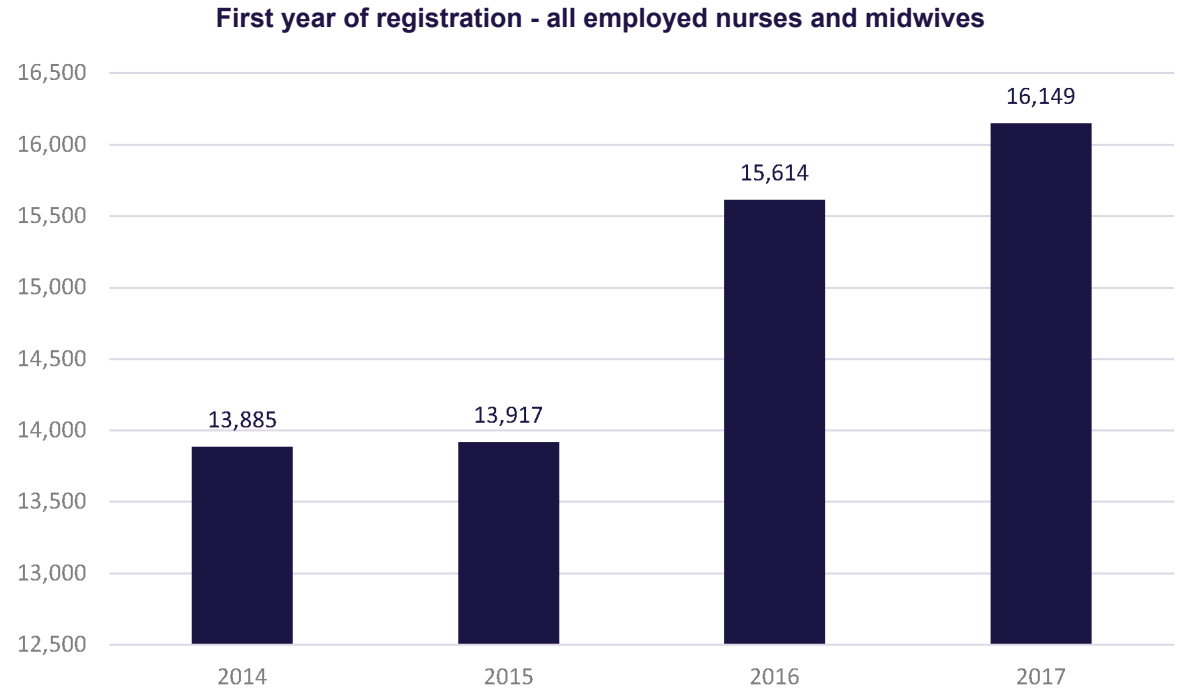
First time registrations - All nurses and midwives [RNS, ENs and Direct Entry Midwives]

- The 2017 figures show first time registrations increasing by 5.5% compared to a 13% increase between 2015 and 2016.



First year of registration - all employed nurses and midwives [RNS, ENs and Direct Entry Midwives]

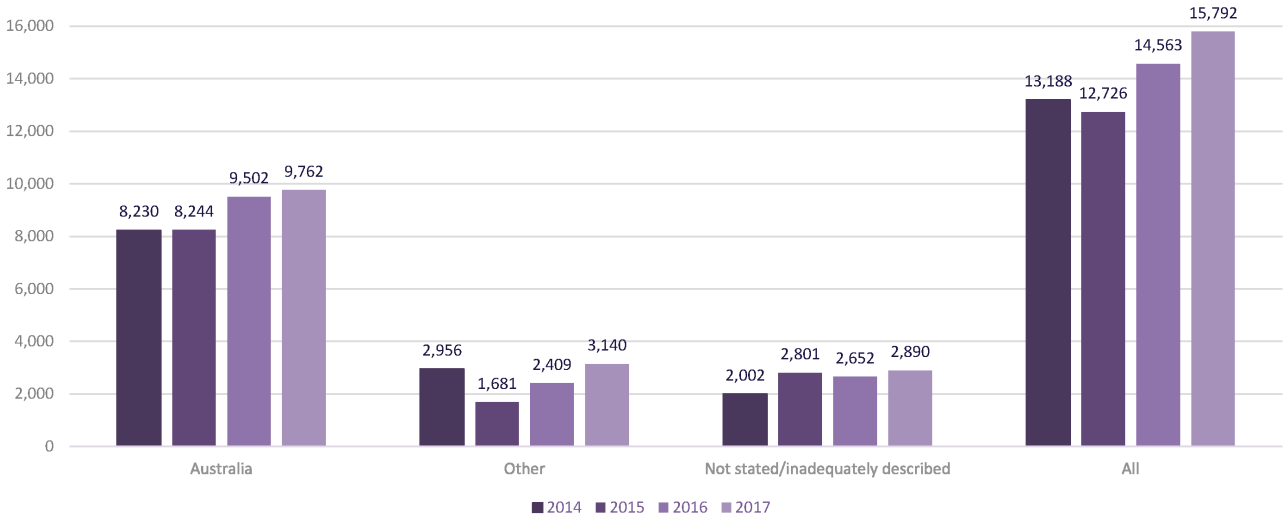
- The number of employed nurses and midwives increased by 3.4% between 2016 and 2017. The percentage employed has remained relatively stable over the 2014-2017 period with approximately 77% - 79% of first time registrants employed.



First time registrations - Registered Nurses [RNs]

- Numbers of RNs registering for the first time increased by 8.4% between 2016 and 2017 after falling 3.5% between 2014 and 2015. Since 2014 numbers have increased by almost 20%.

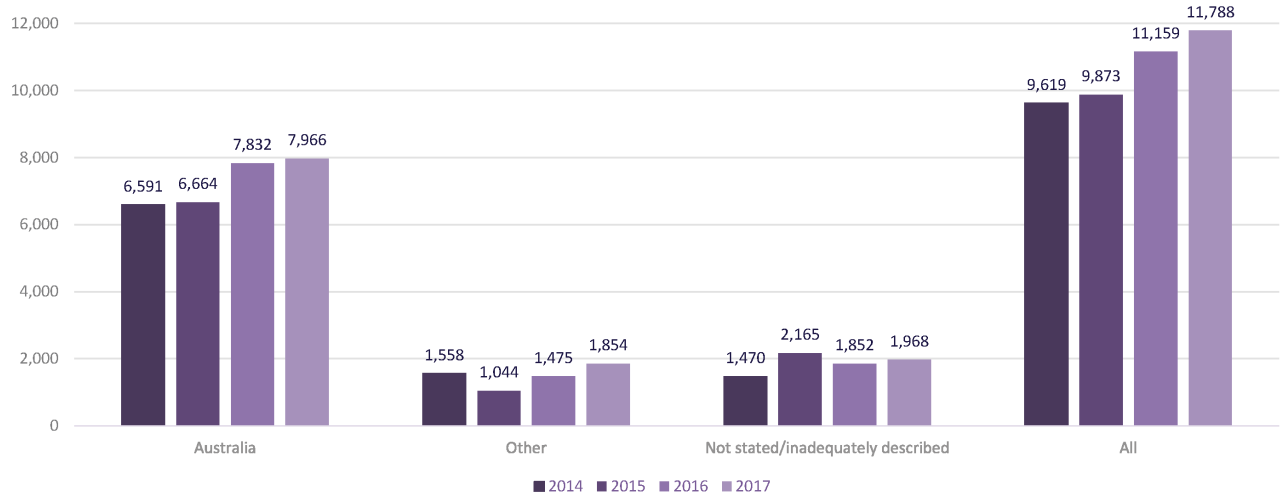
First year of registration for registered nurses by country of first qualification



First time registrations - employed Registered Nurses [RNs]

- The number of first time registered RNs employed in 2017 was 11,788, a 5.6% increase on the previous year's figure of 11,159.
- The 2017 data shows that 75% of RNs registering for the first time were employed, slightly lower than 77% in 2016.

First year of registration for employed registered nurses by country of first qualification

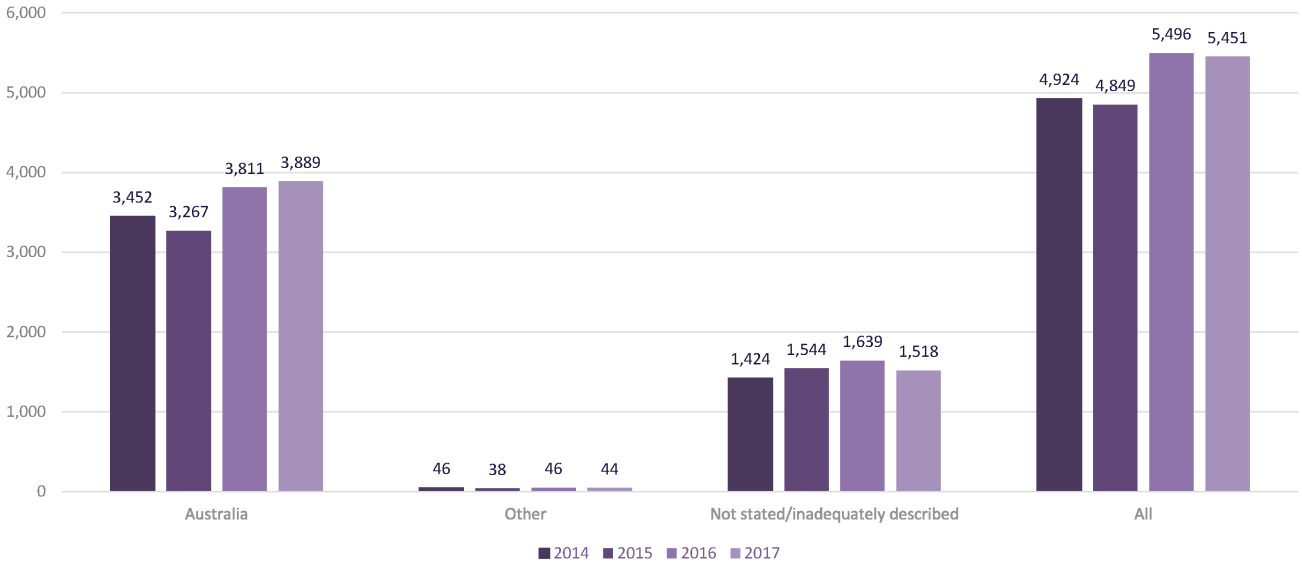


NB: Not stated/inadequately described refers to the number of respondents that did not answer this question on the workforce survey form or answered inadequately and includes non-respondents to the survey.

First time registrations - Enrolled Nurses [ENs]

- The data shows first time registrations for ENs decreased slightly in 2017 after 16.7% in 2016.

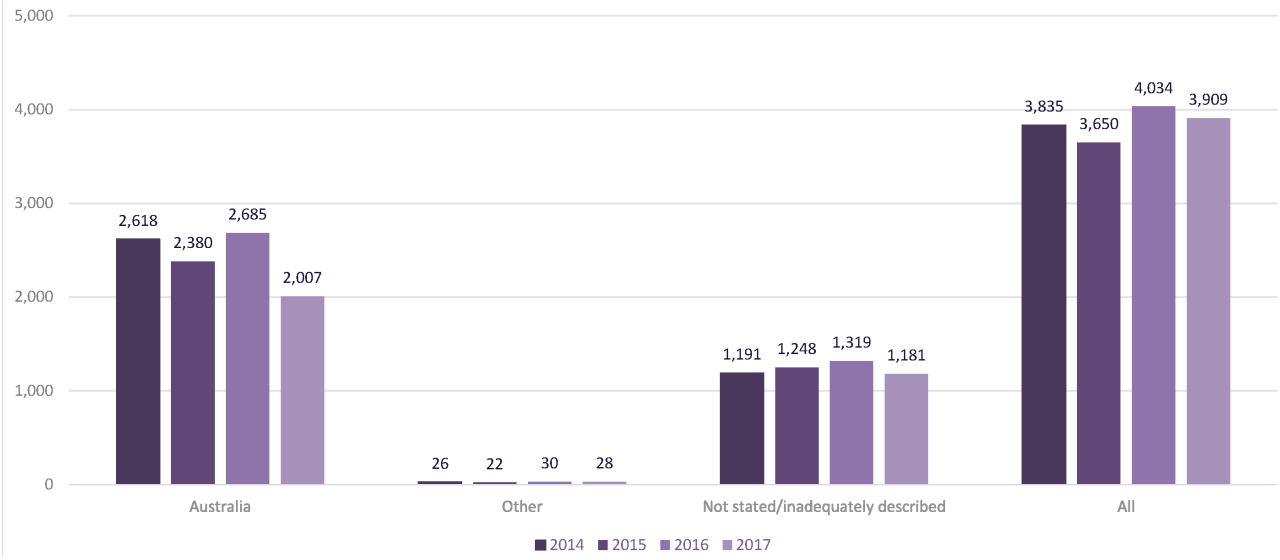
First year of registration for enrolled nurses by country of first qualification



First time registrations - employed Enrolled Nurses [ENs]

- The number of employed ENs decreased 3% in 2017 following a 10% increase in 2016.
- In 2017, 72% of ENs registering for the first time were employed. Since 2014, the figures show a decline in percentage employed from 78%, 76% in 2015 and 73% in 2016.

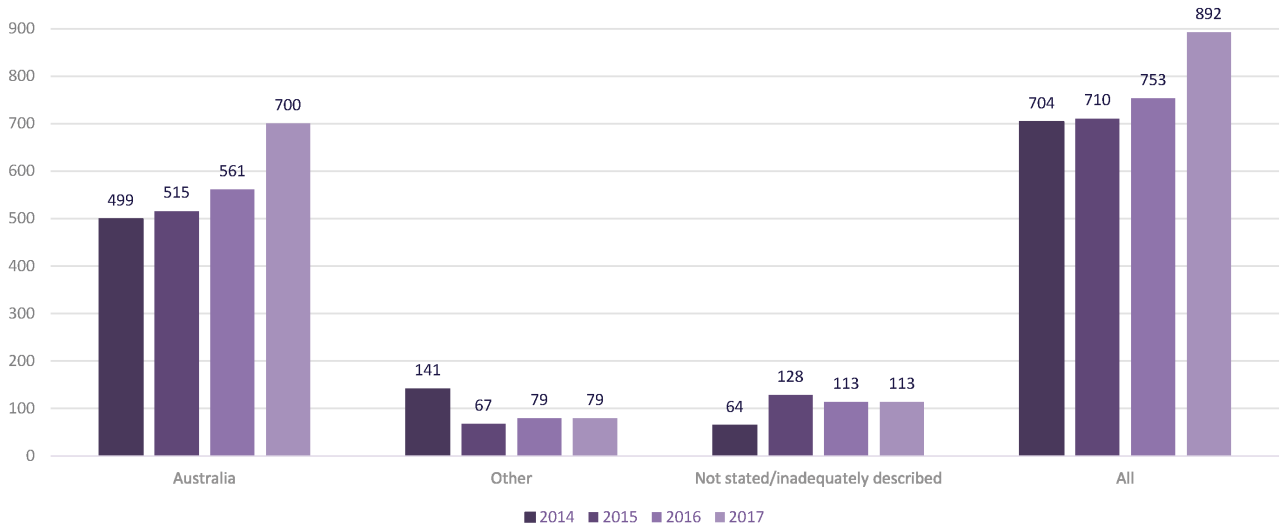
First year of registration for employed enrolled nurses by country of first qualification



First time registrations – Direct Entry Midwives

- The number of first time registrations for midwives increased 18.5% in 2017, the largest increase since 2014.

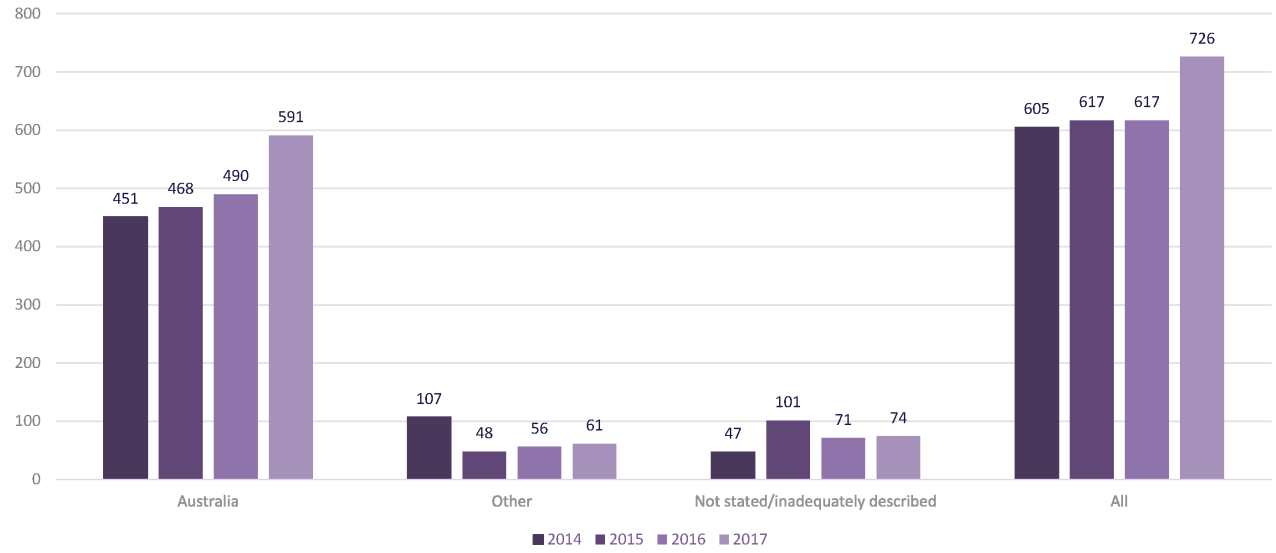
First year of registration for all midwives (regardless of whether working in midwifery) by country of first qualification



First time registrations - employed Direct Entry Midwives

- The number of midwives registering for the first time in 2017 and working in midwifery increased by 17.7% on the previous year.

First year of registration for midwives working in midwifery by country of first qualification



PART 1 - STUDENT COMMENCEMENTS PER YEAR IN A COURSE LEADING TO REGISTRATION

Table 1.1: Number of commencements for initial registration as a nurse by citizenship, 2012-2017

A general nursing course required for initial registration

National by citizenship	2012	2013	2014	2015	2016	2017
Australian citizen	14,141	15,108	16,174	17,617	18,874	19,071
New Zealand citizen	164	200	196	214	266	275
Permanent resident	922	867	959	984	980	1,106
Temporary entry permit	2,357	2,576	2,717	3,023	3,343	3,770
Other overseas	115	93	93	76	74	7
Permanent humanitarian visa	163	145	127	135	108	133
TOTAL	**17,862**	**18,989**	**20,266**	**22,049**	**23,645**	**24,362**

(a)The data takes into account the coding of Combined Courses to two fields of education. As a consequence, counting both fields of education for Combined Courses means that the totals may be less than the sum of all broad fields of education

Table 1.2: Number of commencements for initial registration as a nurse by citizenship, 2012-2017

A general nursing course required for initial registration

State/Territory by citizenship		2012	2013	2014	2015	2016	2017
TOTAL		**17,862**	**18,989**	**20,266**	**22,049**	**23,645**	**24,362**
New South Wales	Australian citizen	3,167	3,487	3,930	4,034	4,082	4,328
	New Zealand citizen	27	38	34	31	43	41
	Permanent resident	201	212	246	223	243	315
	Temporary entry permit	618	659	673	767	885	957
	Other overseas	68	55	44	33	33	6
	Permanent humanitarian visa	34	42	34	28	25	39
	TOTAL	**4,115**	**4,493**	**4,961**	**5,116**	**5,311**	**1,358**
Victoria	Australian citizen	2,420	2,492	2,678	2,805	3,700	3,502
	New Zealand citizen	19	26	31	24	49	54
	Permanent resident	118	109	107	130	137	147
	Temporary entry permit	379	441	435	541	666	682
	Other overseas	0	0	0	< 5	< 5	0
	Permanent humanitarian visa	27	35	20	22	28	29
	TOTAL	**2,963**	**3,103**	**3,271**	**3,522**	**4,580**	**4,414**
Queensland	Australian citizen	3,277	3,446	3,534	4,134	4,479	4,992
	New Zealand citizen	63	64	60	79	84	106
	Permanent resident	176	140	138	152	143	158
	Temporary entry permit	299	327	413	403	481	595
	Permanent humanitarian visa	24	20	15	31	17	27
	TOTAL	**3,839**	**3,997**	**4,160**	**4,799**	**5,204**	**5,878**

Western Australia	Australian citizen	1,492	1,602	1,758	1,748	1,990	2,083
	New Zealand citizen	24	38	35	43	42	41
	Permanent resident	124	147	123	140	145	136
	Temporary entry permit	149	186	193	213	241	292
	Other overseas	0	0	< 5	0	0	< 5
	Permanent humanitarian visa	15	11	11	10	6	9
	TOTAL	**1,804**	**1,984**	**2,120**	**2,154**	**2,334**	**2,561**
South Australia	Australian citizen	1,338	1,384	1,278	1,303	1,279	1,281
	New Zealand citizen	5	6	< 5	0	6	6
	Permanent resident	136	103	98	97	89	101
	Temporary entry permit	406	451	335	393	377	475
	Other overseas	46	37	46	41	40	0
	Permanent humanitarian visa	31	15	21	28	19	21
	TOTAL	**1,931**	**1,790**	**1,778**	**1,862**	**1,810**	**1,884**
Tasmania	Australian citizen	445	466	437	545	553	435
	New Zealand citizen	< 5	< 5	< 5	< 5	< 5	< 5
	Permanent resident	48	34	81	63	52	63
	Temporary entry permit	19	7	< 5	24	26	41
	Permanent humanitarian visa	7	9	9	5	0	0
	TOTAL	**519**	**516**	**527**	**637**	**631**	**539**
Northern Territory	Australian citizen	608	570	675	719	735	765
	New Zealand citizen	9	8	8	11	17	6
	Permanent resident	51	52	55	80	71	102
	Temporary entry permit	68	70	84	89	93	83
	Other overseas	< 5	< 5	0	0	0	0
	Permanent humanitarian visa	5	< 5	5	< 5	< 5	6
	TOTAL	**741**	**122**	**827**	**899**	**916**	**962**
Australian Capital Territory	Australian citizen	159	161	253	192	227	206
	New Zealand citizen	< 5	< 5	< 5	< 5	< 5	< 5
	Permanent resident	13	12	17	16	17	12
	Temporary entry permit	36	31	108	126	94	58
	Permanent humanitarian visa	7	< 5	< 5	0	< 5	< 5
	TOTAL	**215**	**209**	**378**	**334**	**338**	**276**
Multi-State	Australian citizen	1,235	1,500	1,631	2,137	1,829	1,479
	New Zealand citizen	15	15	20	22	20	18
	Permanent resident	55	58	94	83	83	72
	Temporary entry permit	383	404	472	467	480	587
	Permanent humanitarian visa	13	8	9	9	7	< 5
	TOTAL	**1,916**	**2,189**	**2,604**	**2,718**	**2,419**	**2,156**

(a) The data takes into account the coding of Combined Courses to two fields of education. As a consequence, counting both fields of education for Combined Courses means that the totals may be less than the sum of all broad fields of education

MIDWIVES: (Note further clarification is required re: separation of midwifery data)
Table 1.3: Midwifery data only extracted from: Number of commencements by detailed field of education and citizenship 2012-2017 - Bachelor's Pass, Bachelor's Graduate entry & Bachelor's Honours numbers

National by citizenship	Field of Education	2012	2013	2014	2015	2016	2017
Australian citizen	Bachelor's Graduate Entry	0	48	45	47	66	64
	Bachelor's Honours	< 5	< 5	6	< 5	< 5	64
	Bachelor's Pass	1046	1312	1386	1276	1263	1219
New Zealand citizen	Bachelor's Graduate Entry						
	Bachelor's Honours	0	0	0	0	0	< 5
	Bachelor's Pass	19	20	13	9	18	9
Permanent resident	Bachelor's Graduate Entry	0	< 5	< 5	< 5	6	< 5
	Bachelor's Honours						
	Bachelor's Pass	25	32	39	31	19	32
Temporary entry permit	Bachelor's Graduate Entry						
	Bachelor's Honours	0	0	0	0	0	8
	Bachelor's Pass	22	19	14	24	26	17
	Bachelor's Honours						
	Bachelor's Pass						
Permanent humanitarian visa	Bachelor's Graduate Entry	0	0	0	0	< 5	0
	Bachelor's Honours						
	Bachelor's Pass	< 5	< 5	< 5	< 5	7	< 5
TOTAL		**1,112**	**1,431**	**1,503**	**1,387**	**1,405**	**1,413**

(a)The data takes into account the coding of Combined Courses to two fields of education. As a consequence, counting both fields of education for Combined Courses means that the totals may be less than the sum of all broad fields of education

Table 1.4: Midwifery data by State/Territory extracted from: Number of commencement by detailed field of education and citizenship 2012-2017 - Bachelor's Pass, Bachelor's Graduate entry & Bachelor's Honours numbers

State/ Territory	By citizenship	Field of Education	2012	2013	2014	2015	2016	2017
NSW	Australian citizen	Bachelor's Graduate Entry						
		Bachelor's Honours	0	0	0	< 5	0	0
		Bachelor's Pass	165	218	255	216	192	224
	New Zealand citizen	Bachelor's Pass	< 5	< 5	< 5	0	< 5	< 5
	Permanent resident	Bachelor's Graduate Entry						
		Bachelor's Honours						
		Bachelor's Pass	< 5	8	8	5	< 5	5
	Temporary entry permit	Bachelor's Graduate Entry						
		Bachelor's Honours						
		Bachelor's Pass	0	0	0	5	< 5	< 5
	Other overseas	Bachelor's Honours						
		Bachelor's Pass						
	Permanent humanitarian visa	Bachelor's Pass	0	0	< 5	< 5	0	< 5

State/ Territory	By citizenship	Field of Education	2012	2013	2014	2015	2016	2017
VIC	Australian citizen	Bachelor's Graduate Entry						
		Bachelor's Honours	0	0	< 5	0	0	61
		Bachelor's Pass	244	305	324	250	268	286
	New Zealand citizen	Bachelor's Graduate Entry						
		Bachelor's Honours	0	0	0	0	0	< 5
		Bachelor's Pass	< 5	5	< 5	< 5	8	7
	Permanent resident	Bachelor's Graduate Entry						
		Bachelor's Honours						
		Bachelor's Pass	5	< 5	5	< 5	< 5	< 5
	Temporary entry permit	Bachelor's Graduate Entry						
		Bachelor's Honours	0	0	0	0	0	8
		Bachelor's Pass	7	< 5	< 5	7	12	< 5
	Other overseas	Bachelor's Pass						
	Permanent humanitarian visa	Bachelor's Pass	0	< 5	0	0	< 5	0
QLD	Australian citizen	Bachelor's Graduate Entry	0	0	0	0	24	57
		Bachelor's Honours	0	0	0	< 5	0	< 5
		Bachelor's Pass	211	299	270	214	210	214
	New Zealand citizen	Bachelor's Graduate Entry						
		Bachelor's Pass	< 5	5	5	< 5	< 5	0
	Permanent resident	Bachelor's Graduate Entry	0	0	0	0	0	< 5
		Bachelor's Pass	7	6	8	7	5	11
	Temporary entry permit	Bachelor's Graduate Entry						
		Bachelor's Honours						
		Bachelor's Pass	< 5	< 5	< 5	< 5	5	< 5
	Other overseas	Bachelor's Pass						
	Permanent humanitarian visa	Bachelor's Pass	0	0	0	0	< 5	0
WA	Australian citizen	Bachelor's Honours						
		Bachelor's Pass	19	46	46	53	57	63
	New Zealand citizen	Bachelor's Pass	0	< 5	0	0	0	0
	Permanent resident	Bachelor's Pass	< 5	5	< 5	7	< 5	< 5
	Temporary entry permit	Bachelor's Pass						
		Bachelor's Honours						
	Other overseas	Bachelor's Pass						
	Permanent humanitarian visa	Bachelor's Pass	0	0	0	0	< 5	0

State/ Territory	By citizenship	Field of Education	2012	2013	2014	2015	2016	2017
SA	Australian citizen	Bachelor's Graduate Entry						
		Bachelor's Honours						
		Bachelor's Pass	145	167	186	192	169	160
	New Zealand citizen	Bachelor's Graduate Entry						
		Bachelor's Pass	< 5	< 5	< 5	0	< 5	0
	Permanent resident	Bachelor's Graduate Entry						
		Bachelor's Honours						
		Bachelor's Pass	6	8	5	< 5	< 5	7
	Temporary entry permit	Bachelor's Graduate Entry						
		Bachelor's Pass	11	14	5	7	< 5	6
	Other overseas	Bachelor's Pass						
	Permanent humanitarian visa	Bachelor's Graduate Entry						
		Bachelor's Pass	< 5	< 5	0	0	< 5	< 5
TAS	Australian citizen	Bachelor's Honours						
		Bachelor's Pass						
	New Zealand citizen	Bachelor's Honours						
		Bachelor's Pass						
	Permanent resident	Bachelor's Honours						
		Bachelor's Pass						
	Temporary entry permit	Bachelor's Honours						
		Bachelor's Pass						
	Other overseas	Bachelor's Pass						
	Permanent humanitarian visa	Bachelor's Honours						
		Bachelor's Pass						
NT	Australian citizen	Bachelor's Pass	42	50	51	59	83	67
	New Zealand citizen	Bachelor's Pass	< 5	< 5	0	0	< 5	0
	Permanent resident	Bachelor's Pass	< 5	< 5	< 5	< 5	< 5	< 5
	Temporary entry permit	Bachelor's Pass	< 5	0	5	< 5	< 5	< 5
	Other overseas	Bachelor's Pass						
	Permanent humanitarian visa	Bachelor's Pass						

State/ Territory	By citizenship	Field of Education	2012	2013	2014	2015	2016	2017
ACT	Australian citizen	Bachelor's Pass	0	< 5	< 5	< 5	< 5	< 5
	New Zealand citizen	Bachelor's Pass	30	46	33	30	38	38
	Permanent resident	Bachelor's Pass	0	0	0	< 5	0	0
	Temporary entry permit	Bachelor's Pass	< 5	< 5	< 5	< 5	0	< 5
	Other overseas	Bachelor's Pass	0	< 5	0	< 5	0	< 5
	Permanent humanitarian visa	Bachelor's Pass						
Multi-State	Australian citizen	Bachelor's Graduate Entry	0	48	45	47	42	7
		Bachelor's Honours	< 5	< 5	< 5	0	< 5	0
		Bachelor's Pass	190	181	221	253	246	167
	New Zealand citizen	Bachelor's Pass	5	< 5	< 5	< 5	< 5	0
	Permanent resident	Bachelor's Graduate Entry	0	< 5	< 5	< 5	6	< 5
		Bachelor's Honours						
		Bachelor's Pass	< 5	< 5	< 5	< 5	< 5	< 5
	Temporary entry permit	Bachelor's Honours						
		Bachelor's Pass	< 5	0	0	0	0	0
	Permanent humanitarian visa	Bachelor's Honours	0	0	0	0	< 5	0
		Bachelor's Pass	0	0	0	0	< 5	0

(a)The data takes into account the coding of Combined Courses to two fields of education. As a consequence, counting both fields of education for Combined Courses means that the totals may be less than the sum of all broad fields of education

Table 1.5: Number of commencements for initial registration as a nurse by Indigenous status, 2012-2017

National by indigenous status	2012			2013			2014		
	Indigenous	Non-indige	Total	Indigenous	Non-indige	Total	Indigenous	Non-indige	Total
Bachelor's Graduate Entry	0	362	362	< 5	333	335	< 5	382	383
Bachelor's Honours	0	< 5	< 5	0	< 5	< 5	0	< 5	< 5
Bachelor's Pass	356	16,743	17,099	386	17,778	18,164	420	18,956	19,376
TOTAL	**356**	**17,107**	**17,463**	**388**	**18,114**	**18,502**	**421**	**19,341**	**19,762**

	2015			2016			2017		
	Indigenous	Non-indige	Total	Indigenous	Non-indige	Total	Indigenous	Non-indige	Total
Bachelor's Graduate Entry	0	350	350	< 5	393	395	< 5	454	455
Bachelor's Honours	< 5	< 5	< 5	0	< 5	< 5	0	71	71
Bachelor's Pass	485	20,868	21,353	557	22,400	22,957	563	22,962	23,525
TOTAL	**486**	**21,219**	**21,705**	**559**	**22,795**	**23,354**	**564**	**23,487**	**24,051**

Table 1.6: Number of commencements for initial registration as a nurse by Indigenous status, 2012-2017

State/Territory/course level		2012		2013		2014		2015		2016		2017	
		Indigenous	Non-Indige	Indigenous	Non-Indige	Indigenous	Non-Indige	Indigenous	Non-Indige	Indigenous	Non-Indige	Indigenous	Non-Indige
NSW	Bachelors Graduate Entry	0	111	0	99	0	142	0	117	0	135	0	96
	Bachelor's Honours	0	0	0	< 5	0	< 5	< 5	0	0	< 5	0	< 5
	Bachelors Pass	92	3,732	98	4,083	136	4,480	131	4,667	146	4,881	175	5,269
VIC	Bachelors Graduate Entry	0	70	< 5	**46**	**0**	**47**	**0**	**32**	**0**	**51**	**< 5**	**96**
	Bachelor's Honours	0	0	0	0	0	< 5	0	0	0	0	0	70
	Bachelors Pass	39	2,751	49	2,896	38	2,962	40	3,344	56	4,368	39	4,090
QLD	Bachelors Graduate Entry	0	29	0	42	< 5	51	0	60	< 5	55	0	98
	Bachelor's Honours	0	< 5	0	< 5	0	< 5	0	< 5	0	< 5	0	0
	Bachelors Pass	116	3,692	117	3,820	112	3,958	184	4,518	201	4,909	200	5,580
WA	Bachelor's Pass	20	1,740	30	1,913	34	2,047	32	2,122	31	2,393	39	2,475
SA	Bachelor's Graduate Entry	0	152	< 5	146	0	142	0	141	< 5	152	0	164
	Bachelor's Pass	26	1,712	21	1,721	22	1,618	25	1,696	23	1,634	22	1,698
TAS	Bachelor's Pass	9	511	13	507	12	522	21	619	18	616	11	529
NT	Bachelor's Pass	46	696	36	668	39	788	30	871	43	877	47	915
ACT	Bachelor's Pass	< 5	215	< 5	206	6	376	7	328	< 5	338	< 5	277
Multi-State	Bachelor's Pass	7	1,694	21	1,964	21	2,205	15	2,703	35	2,384	28	2,129

(a) The data takes into account the coding of Combined Courses to two fields of education. As a consequence, counting both fields of education for Combined Courses means that the totals may be less than the sum of all broad fields of education

PART 2 - STUDENT COMPLETIONS PER YEAR IN A COURSE LEADING TO REGISTRATION

Table 2.1: Number of completions for initial registration as a nurse by citizenship, 2012-2017

A general nursing course required for initial registration

National by citizenship	2012	2013	2014	2015	2016	2017
Australian citizen	8,063	8,481	8,991	9,254	10,399	10,849
New Zealand citizen	67	77	93	105	121	119
Permanent resident	342	431	467	410	465	512
Temporary entry permit	2,048	1,967	1,922	2,141	2,324	2,399
Other overseas	71	68	87	81	78	62
Permanent humanitarian visa	44	60	80	50	56	69
TOTAL	**10,635**	**11,084**	**11,640**	**12,041**	**13,443**	**14,010**

Table 2.2: Number of completions for initial registration as a nurse by citizenship, 2012-2017

A general nursing course required for initial registration

State/Territory by citizenship		2012	2013	2014	2015	2016	2017
New South Wales	Australian citizen	1,957	1,885	2,181	2,388	2,617	2,733
	New Zealand citizen	8	12	14	23	19	16
	Permanent resident	84	99	102	108	120	137
	Temporary entry permit	393	423	490	565	571	655
	Other overseas	43	47	53	43	34	16
	Permanent humanitarian visa	12	24	22	8	17	20
	TOTAL	**2,497**	**2,490**	**2,862**	**3,135**	**3,378**	**3,577**
Victoria	Australian citizen	1,557	1,659	1,550	1,570	1,888	1,910
	New Zealand citizen	12	10	18	9	15	20
	Permanent resident	48	59	55	33	63	66
	Temporary entry permit	401	410	308	303	415	443
	Other overseas	0	0	0	0	< 5	0
	Permanent humanitarian visa	6	5	14	13	11	9
	TOTAL	**2,024**	**2,143**	**1,945**	**1,928**	**2,392**	**2,448**
Queensland	Australian citizen	1,788	1,827	2,007	2,103	2,228	2,396
	New Zealand citizen	30	31	36	40	49	45
	Permanent resident	59	75	72	80	77	78
	Temporary entry permit	348	339	292	316	347	398
	Other overseas	14	< 5	0	0	0	0
	Permanent humanitarian visa	7	8	12	10	10	13
	TOTAL	**2,246**	**2,280**	**2,419**	**2,549**	**2,711**	**2,930**

Western Australia	Australian citizen	847	925	1,081	1,041	1,205	1,220
	New Zealand citizen	10	16	16	17	13	29
	Permanent resident	53	76	58	69	73	92
	Temporary entry permit	113	126	126	147	198	210
	Other overseas	< 5	0	0	0	0	< 5
	Permanent humanitarian visa	8	5	5	< 5	5	8
	TOTAL	**1,031**	**1,148**	**1,286**	**1,274**	**1,494**	**1,559**
South Australia	Australian citizen	822	809	806	800	872	887
	New Zealand citizen	< 5	< 5	< 5	< 5	< 5	< 5
	Permanent resident	49	49	77	58	57	38
	Temporary entry permit	321	277	287	272	322	305
	Other overseas	13	20	34	36	43	45
	Permanent humanitarian visa	5	12	14	10	6	10
	TOTAL	**1,210**	**1,167**	**1,218**	**1,176**	**1,300**	**1,285**
Tasmania	Australian citizen	190	356	315	224	379	392
	New Zealand citizen	0	0	0	< 5	< 5	< 5
	Permanent resident	5	21	24	5	29	31
	Temporary entry permit	27	17	19	7	9	9
	Permanent humanitarian visa	< 5	< 5	< 5	< 5	< 5	7
	TOTAL	**222**	**394**	**358**	**236**	**417**	**439**
Northern Territory	Australian citizen	203	235	215	187	245	272
	New Zealand citizen	0	< 5	< 5	< 5	5	< 5
	Permanent resident	10	16	31	15	11	22
	Temporary entry permit	18	26	46	34	44	66
	Other overseas	0	0	0	< 5	0	0
	Permanent humanitarian visa	< 5	0	< 5	< 5	0	0
	TOTAL	**231**	**277**	**292**	**236**	**305**	**360**
Australian Capital Territory	Australian citizen	86	99	85	78	93	87
	Permanent resident	8	6	6	< 5	< 5	< 5
	Temporary entry permit	22	28	31	72	91	56
	Permanent humanitarian visa	< 5	< 5	< 5	< 5	< 5	0
	TOTAL	**116**	**133**	**122**	**150**	**184**	**143**
Multi-State	Australian citizen	613	686	751	863	872	952
	New Zealand citizen	6	5	5	10	15	< 5
	Permanent resident	26	30	42	38	34	44
	Temporary entry permit	405	321	323	425	327	257
	Permanent humanitarian visa	< 5	< 5	< 5	< 5	< 5	< 5
	TOTAL	**1,050**	**1,042**	**1,121**	**1,336**	**1,248**	**1,253**

(a) The data takes into account the coding of Combined Courses to two fields of education. As a consequence, counting both fields of education for Combined Courses means that the totals may be less than the sum of all broad fields of education.

MIDWIVES: (Note further clarification is required re: separation of midwifery data)

Table 2.3: Midwifery data only extracted from: Number of completions by detailed field of education and citizenship, 2012-2017 - Bachelor's Pass, Bachelor's Graduate entry & Bachelor's Honours numbers

National by citizenship	Field of Education	2012	2013	2014	2015	2016	2017
Australian citizen	Bachelor's Graduate Entry	0	0	21	18	20	25
	Bachelor's Honours	<5	5	6	<5	6	6
	Bachelor's Pass	495	552	584	568	808	821
New Zealand citizen	Bachelor's Graduate Entry						
	Bachelor's Honours						
	Bachelor's Pass	<5	5	9	<5	13	7
Permanent resident	Bachelor's Graduate Entry	0	0	0	<5	<5	<5
	Bachelor's Honours						
	Bachelor's Pass	7	11	8	17	10	14
Temporary entry permit	Bachelor's Graduate Entry						
	Bachelor's Honours						
	Bachelor's Pass	14	8	<5	13	9	10
Other overseas	Bachelor's Graduate Entry	0	0	0	0	<5	0
	Bachelor's Honours						
	Bachelor's Pass						
Permanent humanitarian visa	Bachelor's Graduate Entry						
	Bachelor's Honours	0	0	0	0	<5	0
	Bachelor's Pass	<5	<5	<5	<5	0	<5
TOTAL		**516**	**576**	**628**	**616**	**866**	**883**

(a) The data takes into account the coding of Combined Courses to two fields of education. As a consequence, counting both fields of education for Combined Courses means that the totals may be less than the sum of all broad fields of education.

Table 2.4: Midwifery data by State/Territory extracted from: Number of completions by detailed field of education and citizenship, 2012-2017 - Bachelor's Pass, Bachelor's Graduate entry & Bachelor's Honours numbers

State	By citizenship	Field of Education	2012	2013	2014	2015	2016	2017
NSW	Australian citizen	Bachelor's Graduate Entry						
		Bachelor's Honours	< 5	0	< 5	0	< 5	< 5
		Bachelor's Pass	50	89	98	95	141	161
	New Zealand citizen	Bachelor's Pass	< 5	0	< 5	< 5	< 5	< 5
	Permanent resident	Bachelor's Graduate Entry						
		Bachelor's Honours						
		Bachelor's Pass	< 5	< 5	0	< 5	< 5	< 5
	Temporary entry permit	Bachelor's Graduate Entry						
		Bachelor's Honours						
		Bachelor's Pass	0	0	0	< 5	0	< 5
	Other overseas	Bachelor's Graduate Entry						
		Bachelor's Honours						
		Bachelor's Pass						
	Permanent humanitarian visa	Bachelor's Graduate Entry						
		Bachelor's Pass						
VIC	Australian citizen	Bachelor's Graduate Entry						
		Bachelor's Honours	0	< 5	0	< 5	0	0
		Bachelor's Pass	160	126	167	111	202	169
	New Zealand citizen	Bachelor's Graduate Entry						
		Bachelor's Pass	0	0	< 5	0	< 5	< 5
	Permanent resident	Bachelor's Graduate Entry						
		Bachelor's Honours	< 5	0	0	0	0	< 5
		Bachelor's Pass	0	< 5	< 5	< 5	< 5	0
	Temporary entry permit	Bachelor's Graduate Entry						
		Bachelor's Honours						
		Bachelor's Pass	< 5	0	0	0	< 5	0
	Other overseas	Bachelor's Pass						
	Permanent humanitarian visa	Bachelor's Honours	0	0	0	0	< 5	0
		Bachelor's Pass	0	< 5	< 5	< 5	0	< 5

State	By citizenship	Field of Education	2012	2013	2014	2015	2016	2017
QLD	Australian citizen	Bachelor's Graduate Entry	0	0	0	0	0	< 5
		Bachelor's Honours	0	< 5	0	0	0	< 5
		Bachelor's Pass	112	107	129	120	170	193
	New Zealand citizen	Bachelor's Graduate Entry						
		Bachelor's Pass	< 5	< 5	< 5	< 5	< 5	< 5
	Permanent resident	Bachelor's Graduate Entry						
		Bachelor's Honours						
		Bachelor's Pass	< 5	< 5	< 5	5	< 5	< 5
	Temporary entry permit	Bachelor's Graduate Entry						
		Bachelor's Honours						
		Bachelor's Pass	< 5	< 5	< 5	0	< 5	< 5
	Other overseas	Bachelor's Pass						
	Permanent humanitarian visa	Bachelor's Pass						
WA	Australian citizen	Bachelor's Honours						
		Bachelor's Pass	0	10	12	24	30	32
	New Zealand citizen	Bachelor's Pass	0	0	0	0	< 5	0
	Permanent resident	Bachelor's Graduate Entry						
		Bachelor's Honours						
		Bachelor's Pass	0	0	0	< 5	0	< 5
	Temporary entry permit	Bachelor's Graduate Entry						
		Bachelor's Pass						
	Other overseas	Bachelor's Pass						
	Permanent humanitarian visa	Bachelor's Pass						
SA								
	Australian citizen	Bachelor's Graduate Entry						
		Bachelor's Honours	0	< 5	< 5	0	0	< 5
		Bachelor's Pass	75	81	66	80	118	120
	New Zealand citizen	Bachelor's Graduate Entry						
		Bachelor's Pass	< 5	< 5	< 5	0	< 5	0
	Permanent resident	Bachelor's Graduate Entry						
		Bachelor's Pass	< 5	< 5	< 5	6	< 5	< 5
	Temporary entry permit	Bachelor's Graduate Entry						
		Bachelor's Honours						
		Bachelor's Pass	10	5	< 5	11	5	< 5
	Other overseas	Bachelor's Pass						
	Permanent humanitarian visa	Bachelor's Graduate Entry						
		Bachelor's Pass						

State	By citizenship	Field of Education	2012	2013	2014	2015	2016	2017
TAS	Australian citizen	Bachelor's Honours						
		Bachelor's Pass						
	New Zealand citizen	Bachelor's Honours						
		Bachelor's Pass						
	Permanent resident	Bachelor's Honours						
		Bachelor's Pass						
	Temporary entry permit	Bachelor's Honours						
		Bachelor's Pass						
	Other overseas	Bachelor's Honours						
		Bachelor's Pass						
	Permanent humanitarian visa	Bachelor's Honours						
		Bachelor's Pass						
NT	Australian citizen	Bachelor's Pass	0	7	10	10	14	34
	New Zealand citizen	Bachelor's Pass	0	0	< 5	0	< 5	0
	Permanent resident	Bachelor's Pass	0	< 5	0	0	0	< 5
	Temporary entry permit	Bachelor's Pass	0	0	0	0	0	< 5
	Other overseas	Bachelor's Pass						
	Permanent humanitarian visa	Bachelor's Pass						
ACT	Australian citizen	Bachelor's Honours	0	< 5	< 5	< 5	< 5	< 5
		Bachelor's Pass	17	25	17	29	22	24
	New Zealand citizen	Bachelor's Pass						
	Permanent resident	Bachelor's Pass	0	0	0	0	0	< 5
	Temporary entry permit	Bachelor's Pass	0	0	0	0	0	< 5
	Permanent humanitarian visa	Bachelor's Pass						
Multi-State	Australian citizen	Bachelor's Graduate Entry	0	0	21	18	20	22
		Bachelor's Honours	0	< 5	< 5	< 5	0	0
		Bachelor's Pass	81	107	85	99	111	88
	New Zealand citizen	Bachelor's Pass	< 5	< 5	< 5	< 5	< 5	< 5
	Permanent resident	Bachelor's Graduate Entry	0	0	0	< 5	< 5	< 5
		Bachelor's Honours						
		Bachelor's Pass	< 5	< 5	< 5	0	< 5	< 5
	Temporary entry permit	Bachelor's Honours						
		Bachelor's Pass						
	Permanent humanitarian visa	Bachelor's Pass	< 5	0	0	0	0	0

(a) The data takes into account the coding of Combined Courses to two fields of education. As a consequence, counting both fields of education for Combined Courses means that the totals may be less than the sum of all broad fields of education.

Table 2.5: Indigenous and non-indigenous students data by State/Territory extracted from: Number of completions by detailed field of education and Indigenous status, 2012-2017

National by indigenous status	2012			2013			2014		
	Indigenous	Non-indige	Total	Indigenous	Non-indige	Total	Indigenous	Non-indige	Total
Bachelor's Graduate Entry	< 5	208	209	< 5	285	286	0	276	276
Bachelor's Honours	0	0	0	0	< 5	< 5	0	< 5	< 5
Bachelor's Pass	102	10,063	10,165	125	10,376	10,501	143	10,905	11,048
TOTAL	**103**	**10,271**	**10,374**	**126**	**10,665**	**10,791**	**143**	**11,182**	**11,325**

	2015			2016			2017		
	Indigenous	Non-indige	Total	Indigenous	Non-indige	Total	Indigenous	Non-indige	Total
Bachelor's Graduate Entry	0	283	283	0	286	286	< 5	330	331
Bachelor's Honours	0	5	5	0	7	7	0	< 5	< 5
Bachelor's Pass	139	11,338	11,477	201	12,716	12,917	204	13,233	13,437
TOTAL	**139**	**11,626**	**11,765**	**201**	**13,009**	**13,210**	**205**	**13,567**	**13,772**

Table 2.6: Indigenous and non-indigenous students data by State/Territory extracted from: Number of completions by detailed field of education and Indigenous status, 2012-2017

State/Territory/course level		2012		2013		2014		2015		2016		2017	
		Indigenous	Non-Indige	Indigenous	Non-Indige	Indigenous	Non-Indige	Indigenous	Non-Indige	Indigenous	Non-Indige	Indigenous	Non-Indige
NSW	Bachelors Graduate Entry	< 5	75	0	107	0	99	0	110	0	105	0	119
	Bachelor's Honours	0	0	0	< 5	0	< 5	0	< 5	0	< 5	0	< 5
	Bachelors Pass	27	2,241	33	2,163	47	2,522	50	2,870	58	3,098	72	3,269
VIC	Bachelors Graduate Entry	0	45	0	**68**	**0**	**37**	**0**	**38**	**0**	**30**	**0**	**41**
	Bachelor's Honours	0	0	0	< 5	0	0	0	< 5	0	< 5	0	0
	Bachelors Pass	13	1,898	19	1,977	20	1,808	12	1,790	25	2,248	15	2,303
QLD	Bachelors Graduate Entry	0	< 5	0	15	0	22	0	30	0	41	< 5	48
	Bachelor's Honours	0	0	0	< 5	0	0	0	< 5	0	< 5	0	< 5
	Bachelors Pass	33	2,195	39	2,225	43	2,345	37	2,447	66	2,573	60	2,786
WA	Bachelor's Pass	< 5	1,004	6	1,113	6	1,247	13	1,211	18	1,474	16	1,543
SA	Bachelor's Graduate Entry	0	86	< 5	95	0	118	0	105	0	110	0	122
	Bachelor's Pass	11	1,114	5	1,068	7	1,094	12	1,063	14	1,178	10	1,155
TAS	Bachelor's Pass	5	218	13	382	< 5	358	< 5	234	7	416	11	430
NT	Bachelor's Pass	5	227	5	273	8	288	6	234	6	299	6	356
ACT	Bachelor's Pass	< 5	117	< 5	134	0	126	0	155	< 5	183	< 5	145
Multi-State	Bachelor's Pass	< 5	1,049	< 5	1,041	8	1,117	5	1,334	< 5	1,247	12	1,246

(a) The data takes into account the coding of Combined Courses to two fields of education. As a consequence, counting both fields of education for Combined Courses means that the totals may be less than the sum of all broad fields of education

PART 3 - TOTAL STUDENT ENROLMENTS BY YEAR

Table 3.1: Number of enrolments for initial registration as a nurse by citizenship, 2012-2017

National by citizenship	2012	2013	2014	2015	2016	2017
Australian citizen	38,893	41,119	43,742	47,370	50,963	53,393
New Zealand citizen	374	446	492	539	628	709
Permanent resident	1,925	1,964	2,041	2,160	2,217	2,414
Temporary entry permit	6,678	6,566	6,669	7,261	8,024	8,987
Other overseas	203	201	198	178	161	84
Permanent humanitarian visa	348	382	400	385	372	390
TOTAL	**48,421**	**50,678**	**53,542**	**57,893**	**62,365**	**65,977**

Table 3.2: Number of enrolments in a general nursing course required for initial registration for Australia, 2012-2017

State/Territory by citizenship		2012	2013	2014	2015	2016	2017
New South Wales	Australian citizen	9,009	9,609	10,257	11,153	11,693	12,172
	New Zealand citizen	60	74	86	88	97	113
	Permanent resident	414	450	505	527	533	650
	Temporary entry permit	1,564	1,707	1,777	1,914	2,131	2,415
	Other overseas	132	120	89	65	51	21
	Permanent humanitarian	80	102	100	89	89	110
	TOTAL	**11,259**	**12,062**	**12,814**	**13,836**	**14,594**	**15,481**
Victoria	Australian citizen	6,854	6,845	6,961	7,388	8,086	8,847
	New Zealand citizen	47	54	62	58	91	118
	Permanent resident	236	225	218	239	272	295
	Temporary entry permit	1,029	982	915	1,062	1,316	1,501
	Other overseas	0	0	0	< 5	< 5	0
	Permanent humanitarian	53	67	65	56	61	64
	TOTAL	**8,219**	**8,173**	**8,221**	**8,805**	**9,827**	**10,825**
Queensland	Australian citizen	8,748	9,282	10,012	10,941	12,060	13,100
	New Zealand citizen	151	169	172	196	222	248
	Permanent resident	366	353	341	346	340	350
	Temporary entry permit	1,055	965	997	1,043	1,183	1,385
	Other overseas	< 5	0	0	0	0	0
	Permanent humanitarian	52	55	61	76	70	72
	TOTAL	**10,372**	**10,824**	**11,583**	**12,602**	**13,875**	**15,155**

Western Australia	Australian citizen	4,500	4,858	5,303	5,510	6,078	6,492
	New Zealand citizen	60	82	87	107	111	127
	Permanent resident	306	338	298	336	354	338
	Temporary entry permit	419	466	497	543	609	651
	Other overseas	< 5	0	< 5	0	0	< 5
	Permanent humanitarian	39	39	36	36	36	35
	TOTAL	**5,324**	**5,783**	**6,221**	**6,532**	**7,188**	**7,643**
South Australia	Australian citizen	3,518	3,651	3,606	3,602	3,611	3,462
	New Zealand citizen	9	14	11	8	10	12
	Permanent resident	247	223	221	205	192	198
	Temporary entry permit	1,007	995	871	911	958	1,059
	Other overseas	68	79	104	109	109	61
	Permanent humanitarian	62	59	63	64	56	63
	TOTAL	**4,911**	**5,021**	**4,876**	**4,899**	**4,936**	**4,855**
Tasmania	Australian citizen	1,155	1,193	1,215	1,298	1,354	1,246
	New Zealand citizen	< 5	< 5	7	9	6	6
	Permanent resident	81	74	120	111	100	113
	Temporary entry permit	79	54	36	41	49	78
	Permanent humanitarian	18	20	26	23	18	8
	TOTAL	**1,333**	**1,341**	**1,404**	**1,482**	**1,527**	**1,451**
Northern Territory	Australian citizen	1,380	1,472	1,653	1,856	2,054	2,149
	New Zealand citizen	12	13	20	21	33	27
	Permanent resident	105	121	120	161	182	222
	Temporary entry permit	120	160	197	226	274	293
	Other overseas	< 5	< 5	< 5	< 5	0	0
	Permanent humanitarian	9	7	10	9	11	12
	TOTAL	**1,626**	**1,773**	**2,000**	**2,275**	**2,554**	**2,703**
Australian Capital Territory	Australian citizen	471	482	559	602	637	645
	New Zealand citizen	< 5	< 5	< 5	< 5	< 5	5
	Permanent resident	29	22	29	31	38	45
	Temporary entry permit	73	74	152	237	240	193
	Permanent humanitarian	15	13	14	8	7	6
	TOTAL	**580**	**591**	**754**	**881**	**926**	**894**
Multi-State	Australian citizen	3,258	3,727	4,176	5,020	5,390	5,280
	New Zealand citizen	30	35	45	49	54	53
	Permanent resident	141	158	189	204	206	203
	Temporary entry permit	1,332	1,163	1,227	1,284	1,264	1,412
	Permanent humanitarian	20	20	25	24	24	20
	TOTAL	**4,781**	**5,103**	**5,662**	**6,581**	**6,938**	**6,968**

Source: Tables 1.1 to 3.2 Students, Selected Higher Education Statistics, Australian Government Department of Education and Training

PART 4 - ENROLLED NURSE ENROLMENTS (COMMENCEMENT PROGRAM) PER YEAR - INDIGENOUS AND NON-INDIGENOUS STUDENTS

Table 4.1: Commencing program enrolments by Students status, State/territory of residence, Type of accreditation and Indigenous status

Year 2014																
Type of Accreditation	**HLT43407 - Certificate IV in Nursing (Enrolled/ Division 2 nursing)**				**HLT51607 - Diploma of Nursing (Enrolled/ Division 2 nursing)**				**HLT51612 - Diploma of Nursing (Enrolled-Division 2 nursing)**				**HLT54115 - Diploma of Nursing**			
Indigenous status	Indigenous	Non-Indigenous	Not Known	Total	Indigenous	Non-Indigenous	Not Known	Total	Indigenous	Non-Indigenous	Not Known	Total	Indigenous	Non-Indigenous	Not Known	Total
State/territory of residence																
New South Wales	0	0	0	0	0	0	0	0	60	1,120	95	1,280	0	0	0	0
Victoria	0	0	0	0	0	5	0	10	35	4,370	30	4,440	0	0	0	0
Queensland	0	0	0	0	0	0	0	0	60	1,125	170	1,355	0	0	0	0
South Australia	0	0	0	0	5	75	0	80	40	1,695	20	1,755	0	0	0	0
Western Australia	0	0	0	0	0	0	0	0	40	735	85	860	0	0	0	0
Tasmania	0	0	0	0	0	0	0	0	10	195	0	205	0	0	0	0
Northern Territory	0	0	0	0	0	0	0	0	0	30	0	30	0	0	0	0
Australian Capital Territory	0	0	0	0	0	0	0	0	0	65	0	65	0	0	0	0
Other Australian Territories or Dependencies	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Overseas	0	0	0	0	0	5	0	5	0	825	5	830	0	0	0	0
Not known	0	0	0	0	0	15	0	15	5	160	5	170	0	0	0	0
Total	0	0	0	0	5	105	0	110	255	10,320	415	10,985	0	0	0	0

	HLT61107 - Advanced Diploma of Nursing (Enrolled/ Division 2 nursing)				**HLT64115 - Advanced Diploma of Nursing**				**Total**			
New South Wales	5	20	25	45	0	0	0	0	65	1,140	120	1,325
Victoria	0	45	10	55	0	0	0	0	35	4,425	40	4,500
Queensland	0	50	5	55	0	0	0	0	60	1,175	180	1,410
South Australia	5	140	0	145	0	0	0	0	45	1,915	20	1,980
Western Australia	0	35	20	50	0	0	0	0	40	770	105	915
Tasmania	5	45	0	50	0	0	0	0	15	240	0	260
Northern Territory	0	5	0	5	0	0	0	0	0	30	0	35
Australian Capital Territory	0	0	0	0	0	0	0	0	5	65	0	65
Other Australian Territories or Dependencies	0	0	0	0	0	0	0	0	0	0	0	0
Overseas	0	20	0	20	0	0	0	0	0	850	5	855
Not known	0	15	0	15	0	0	0	0	5	185	5	195
Total	15	375	55	445	0	0	0	0	270	10,800	475	11540

Source: National VET Provider Collection 2017 and National VET in Schools Collection 2017

Table 4.2: Commencing program enrolments by Students status, State/territory of residence, Type of accreditation and Indigenous status

Year 2015																
Type of Accreditation	**HLT43407 - Certificate IV in Nursing (Enrolled/ Division 2 nursing)**				**HLT51607 - Diploma of Nursing (Enrolled/ Division 2 nursing)**				**HLT51612 - Diploma of Nursing (Enrolled-Division 2 nursing)**				**HLT54115 - Diploma of Nursing**			
Indigenous status	Indigenous	Non-Indigenous	Not Known	Total	Indigenous	Non-Indigenous	Not Known	Total	Indigenous	Non-Indigenous	Not Known	Total	Indigenous	Non-Indigenous	Not Known	Total
State/territory of residence																
New South Wales	0	0	0	0	0	0	0	0	120	1,435	20	1,575	0	0	0	0
Victoria	0	0	0	0	0	0	0	0	50	3,970	30	4,050	0	0	0	0
Queensland	0	0	0	0	0	0	0	0	95	1,840	115	2,050	0	0	0	0
South Australia	0	0	0	0	0	5	0	5	50	2,415	5	2,470	0	0	0	0
Western Australia	0	0	0	0	0	0	0	0	45	965	85	1,095	0	0	0	0
Tasmania	0	0	0	0	0	0	0	0	5	275	0	280	0	0	0	0
Northern Territory	0	0	0	0	0	0	0	0	5	40	0	45	0	0	0	0
Australian Capital Territory	0	0	0	0	0	0	0	0	5	70	10	80	0	0	0	0
Other Australian Territories or Dependencies	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Overseas	0	0	0	0	0	0	0	0	5	865	20	885	0	0	0	0
Not known	0	0	0	0	0	0	0	0	5	65	5	75	0	0	0	0
Total	0	0	0	0	0	5	0	5	380	11,935	290	12,605	0	0	0	0

	HLT61107 - Advanced Diploma of Nursing (Enrolled/ Division 2 nursing)				**HLT64115 - Advanced Diploma of Nursing**				**Total**			
New South Wales	0	15	5	20	0	0	0	0	120	1,450	25	1,595
Victoria	0	60	0	65	0	0	0	0	50	4,030	30	4,110
Queensland	0	60	5	65	0	0	0	0	95	1,905	115	2,115
South Australia	0	105	0	105	0	0	0	0	50	2,525	5	2,580
Western Australia	0	15	20	40	0	0	0	0	50	980	105	1,130
Tasmania	5	25	0	30	0	0	0	0	10	300	0	310
Northern Territory	0	0	0	0	0	0	0	0	5	40	0	45
Australian Capital Territory	0	0	0	0	0	0	0	0	5	70	10	85
Other Australian Territories or Dependencies	0	0	0	0	0	0	0	0	0	0	0	0
Overseas	0	25	0	25	0	0	0	0	5	890	20	910
Not known	0	5	0	5	0	0	0	0	5	70	10	80
Total	10	315	30	355	0	0	0	0	390	12255	320	12965

Source: National VET Provider Collection 2017 and National VET in Schools Collection 2017

Table 4.3: Commencing program enrolments by Students status, State/territory of residence, Type of accreditation and Indigenous status

Year 2016																
Type of Accreditation	**HLT43407 - Certificate IV in Nursing (Enrolled/ Division 2 nursing)**				**HLT51607 - Diploma of Nursing (Enrolled/ Division 2 nursing)**				**HLT51612 - Diploma of Nursing (Enrolled-Division 2 nursing)**				**HLT54115 - Diploma of Nursing**			
Indigenous status	Indigenous	Non-Indigenous	Not Known	Total	Indigenous	Non-Indigenous	Not Known	Total	Indigenous	Non-Indigenous	Not Known	Total	Indigenous	Non-Indigenous	Not Known	Total
State/territory of residence																
New South Wales	0	0	0	0	0	0	0	0	95	1420	30	1545	0	35	0	35
Victoria	0	0	0	0	0	8	0	11	35	3765	15	3810	5	120	0	125
Queensland	0	0	0	0	0	3	0	3	95	1960	95	2150	5	85	5	95
South Australia	0	0	0	0	5	79	0	79	50	3175	15	3235	0	0	0	0
Western Australia	0	0	0	0	0	0	0	0	60	990	140	1185	0	30	25	55
Tasmania	0	0	0	0	0	0	0	0	5	225	0	230	0	0	0	0
Northern Territory	0	0	0	0	0	0	0	0	0	45	0	50	0	0	0	0
Australian Capital Territory	0	0	0	0	0	0	0	0	0	85	10	100	0	0	0	0
Other Australian Territories or Dependencies	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Overseas	0	0	0	0	0	2	0	2	5	1465	20	1490	0	10	0	10
Not known	0	0	0	0	0	11	0	11	0	70	5	75	0	0	0	0
Total	0	0	0	0	5	108	3	113	340	13,195	330	13870	10	280	30	320

	HLT61107 - Advanced Diploma of Nursing (Enrolled/ Division 2 nursing)				**HLT64115 - Advanced Diploma of Nursing**				**Total**			
New South Wales	0	15	0	20	0	0	0	0	100	1,470	30	1,600
Victoria	0	50	0	50	0	0	0	0	35	3,930	15	3,985
Queensland	0	45	0	50	0	0	0	0	100	2,095	100	2,290
South Australia	5	105	0	105	0	0	0	0	50	3,280	15	3,345
Western Australia	0	5	10	15	0	0	0	0	60	1,020	175	1,255
Tasmania	0	20	0	20	0	0	0	0	5	245	0	250
Northern Territory	0	0	0	0	0	0	0	0	0	50	0	50
Australian Capital Territory	0	0	0	0	0	0	0	0	0	85	10	100
Other Australian Territories or Dependencies	0	0	0	0	0	0	0	0	0	0	0	0
Overseas	0	45	0	45	0	0	0	0	5	1,520	20	1,545
Not known	0	5	0	5	0	0	0	0	0	75	5	80
Total	10	290	15	310	0	0	0	0	360	13,765	375	14,500

Source: National VET Provider Collection 2017 and National VET in Schools Collection 2017

Table 4.4: Commencing program enrolments by Students status, State/territory of residence, Type of accreditation and Indigenous status

Year 2017																
Type of Accreditation	**HLT43407 - Certificate IV in Nursing (Enrolled/ Division 2 nursing)**				**HLT51607 - Diploma of Nursing (Enrolled/Division 2 nursing)**				**HLT51612 - Diploma of Nursing (Enrolled-Division 2 nursing)**				**HLT54115 - Diploma of Nursing**			
Indigenous status	Indigenous	Non-Indigenous	Not Known	Total	Indigenous	Non-Indigenous	Not Known	Total	Indigenous	Non-Indigenous	Not Known	Total	Indigenous	Non-Indigenous	Not Known	Total
State/territory of residence																
New South Wales	0	0	0	0	0	0	0	0	5	140	70	215	100	1505	50	1655
Victoria	0	0	0	0	0	0	0	0	5	265	60	330	40	3815	40	3890
Queensland	0	0	0	0	0	0	0	0	25	625	100	750	65	1475	45	1590
South Australia	0	0	0	0	0	0	0	0	15	1030	35	1080	20	680	10	705
Western Australia	0	0	0	0	0	0	0	0	10	45	5	55	30	925	35	990
Tasmania	0	0	0	0	0	0	0	0	0	5	0	5	10	195	0	200
Northern Territory	0	0	0	0	0	0	0	0	0	45	0	45	0	0	0	0
Australian Capital Territory	0	0	0	0	0	0	0	0	0	0	0	5	0	110	20	130
Other Australian Territories or Dependencies	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Overseas	0	0	0	0	0	0	0	0	0	350	25	375	0	1295	280	1575
Not known	0	0	0	0	0	0	0	0	0	5	0	10	0	60	0	60
Total	0	0	0	0	0	0	0	0	65	2510	300	2875	270	10,050	480	10,800

	HLT61107 - Advanced Diploma of Nursing (Enrolled/ Division 2 nursing)				**HLT64115 - Advanced Diploma of Nursing**				**Total**			
New South Wales	0	20	0	20	0	0	0	0	105	1665	120	1890
Victoria	0	50	0	50	0	25	0	25	45	4155	100	4300
Queensland	0	90	5	90	0	5	0	5	95	2195	150	2435
South Australia	0	15	0	15	0	0	0	0	35	1725	45	1805
Western Australia	0	0	0	0	0	0	0	0	40	970	40	1050
Tasmania	0	0	0	0	0	0	0	0	10	200	0	210
Northern Territory	0	0	0	0	0	0	0	0	0	45	0	45
Australian Capital Territory	0	0	0	0	0	0	0	0	0	110	20	135
Other Australian Territories or Dependencies	0	0	0	0	0	0	0	0	0	0	0	0
Overseas	0	10	0	10	0	0	0	0	0	1655	305	1960
Not known	0	0	0	0	0	0	0	0	5	65	5	75
Total	0	185	5	190	0	35	0	35	335	12,780	785	13,905

Source: National VET Provider Collection 2017 and National VET in Schools Collection 2017

PART 5 - ENROLLED NURSE COMPLETIONS PER YEAR IN A PROGRAM LEADING TO REGISTRATION – ALL TRAINING ACTIVITY - INDIGENOUS AND NON-INDIGENOUS STUDENTS

Table 5.1: Program completions by Students status, State/territory of residence, Type of accreditation and Indigenous status

Year 2014																
Type of Accreditation	**HLT43407 - Certificate IV in Nursing (Enrolled/ Division 2 nursing)**				**HLT51607 - Diploma of Nursing (Enrolled/ Division 2 nursing)**				**HLT51612 - Diploma of Nursing (Enrolled-Division 2 nursing)**				**HLT54115 - Diploma of Nursing**			
Indigenous status	Indigenous	Non-Indigenous	Not Known	Total	Indigenous	Non-Indigenous	Not Known	Total	Indigenous	Non-Indigenous	Not Known	Total	Indigenous	Non-Indigenous	Not Known	Total
State/territory of residence																
New South Wales	0	0	0	0	0	15	0	15	50	790	75	915	0	0	0	0
Victoria	0	30	10	40	0	230	0	235	5	1,495	40	1,545	0	0	0	0
Queensland	0	0	0	0	0	85	10	95	25	1,100	150	1,275	0	0	0	0
South Australia	0	0	0	0	0	35	0	35	5	470	20	500	0	0	0	0
Western Australia	0	0	0	0	0	20	0	20	20	515	10	540	0	0	0	0
Tasmania	0	0	0	0	0	0	0	0	5	105	0	110	0	0	0	0
Northern Territory	0	0	0	0	0	0	0	0	0	15	0	15	0	0	0	0
Australian Capital Territory	0	0	0	0	0	0	0	0	0	40	0	40	0	0	0	0
Other Australian Territories or Dependencies	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Overseas	0	0	0	0	0	20	0	20	0	445	5	450	0	0	0	0
Not known	0	0	0	0	0	10	0	10	0	60	5	60	0	0	0	0
Total	0	30	10	40	5	415	10	430	110	5,040	305	5,455	0	0	0	0

	HLT61107 - Advanced Diploma of Nursing (Enrolled/ Division 2 nursing)				**HLT64115 - Advanced Diploma of Nursing**				**Total**			
New South Wales	0	10	25	35	0	0	0	0	50	820	100	970
Victoria	0	10	5	15	0	0	0	0	5	1,770	55	1,830
Queensland	0	15	0	15	0	0	0	0	25	1,200	160	1,385
South Australia	0	55	5	60	0	0	0	0	5	560	25	590
Western Australia	0	30	5	35	0	0	0	0	20	565	15	595
Tasmania	0	15	0	15	0	0	0	0	5	115	0	125
Northern Territory	0	0	0	0	0	0	0	0	0	15	0	15
Australian Capital Territory	0	0	0	0	0	0	0	0	0	45	0	45
Other Australian Territories or Dependencies	0	0	0	0	0	0	0	0	0	0	0	0
Overseas	0	0	0	0	0	0	0	0	0	465	5	470
Not known	0	5	0	5	0	0	0	0	0	75	5	80
Total	0	145	35	185	0	0	0	0	115	5,630	360	6,110

Source: National VET Provider Collection 2017 and National VET in Schools Collection 2017

Table 5.2: Program completions by Students status, State/territory of residence, Type of accreditation and Indigenous status

Year 2015																
Type of Accreditation	**HLT43407 - Certificate IV in Nursing (Enrolled/ Division 2 nursing)**				**HLT51607 - Diploma of Nursing (Enrolled/ Division 2 nursing)**				**HLT51612 - Diploma of Nursing (Enrolled-Division 2 nursing)**				**HLT54115 - Diploma of Nursing**			
Indigenous status	Indigenous	Non-Indigenous	Not Known	Total	Indigenous	Non-Indigenous	Not Known	Total	Indigenous	Non-Indigenous	Not Known	Total	Indigenous	Non-Indigenous	Not Known	Total
State/territory of residence																
New South Wales	0	0	0	0	0	5	0	5	50	800	35	890	0	0	0	0
Victoria	0	0	0	0	0	10	0	10	10	1,845	35	1,890	0	0	0	0
Queensland	0	0	0	0	0	0	0	0	25	985	90	1,105	0	0	0	0
South Australia	0	0	0	0	0	5	0	5	15	575	15	605	0	0	0	0
Western Australia	0	0	0	0	0	0	0	0	15	480	15	510	0	0	0	0
Tasmania	0	0	0	0	0	0	0	0	0	95	0	95	0	0	0	0
Northern Territory	0	0	0	0	0	0	0	0	0	15	0	15	0	0	0	0
Australian Capital Territory	0	0	0	0	0	0	0	0	0	40	0	45	0	0	0	0
Other Australian Territories or Dependencies	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Overseas	0	0	0	0	0	0	0	0	0	645	5	650	0	0	0	0
Not known	0	0	0	0	0	0	0	0	0	35	5	40	0	0	0	0
Total	0	0	0	0	0	20	0	20	120	5,520	195	5,840	0	0	0	0

	HLT61107 - Advanced Diploma of Nursing (Enrolled/ Division 2 nursing)				**HLT64115 - Advanced Diploma of Nursing**				**Total**			
New South Wales	0	15	5	20	0	0	0	0	50	820	40	915
Victoria	0	30	5	40	0	0	0	0	15	1,885	40	1,940
Queensland	0	10	0	10	0	0	0	0	25	995	90	1,115
South Australia	0	70	0	70	0	0	0	0	15	650	15	680
Western Australia	0	10	15	30	0	0	0	0	15	495	30	540
Tasmania	5	15	0	20	0	0	0	0	5	110	0	115
Northern Territory	0	0	0	0	0	0	0	0	0	15	0	15
Australian Capital Territory	0	0	0	0	0	0	0	0	0	40	0	45
Other Australian Territories or Dependencies	0	0	0	0	0	0	0	0	0	0	0	0
Overseas	0	15	0	15	0	0	0	0	0	660	5	665
Not known	0	5	0	5	0	0	0	0	0	40	5	40
Total	5	170	30	205	0	0	0	0	130	5,710	230	6,065

Source: National VET Provider Collection 2017 and National VET in Schools Collection 2017

Table 5.3: Program completions by Students status, State/territory of residence, Type of accreditation and Indigenous status

Year 2016																
Type of Accreditation	**HLT43407 - Certificate IV in Nursing (Enrolled/ Division 2 nursing)**				**HLT51607 - Diploma of Nursing (Enrolled/ Division 2 nursing)**				**HLT51612 - Diploma of Nursing (Enrolled-Division 2 nursing)**				**HLT54115 - Diploma of Nursing**			
Indigenous status	Indigenous	Non-Indigenous	Not Known	Total	Indigenous	Non-Indigenous	Not Known	Total	Indigenous	Non-Indigenous	Not Known	Total	Indigenous	Non-Indigenous	Not Known	Total
State/territory of residence																
New South Wales	0	0	0	0	0	0	0	0	45	985	15	1,045	0	0	0	0
Victoria	0	0	0	0	0	0	0	0	15	1,925	15	1,955	0	0	0	0
Queensland	0	0	0	0	0	0	0	0	40	1,225	45	1,310	0	0	0	0
South Australia	0	0	0	0	0	0	0	0	5	710	0	715	0	0	0	0
Western Australia	0	0	0	0	0	0	0	0	20	620	15	655	0	0	0	0
Tasmania	0	0	0	0	0	0	0	0	5	90	0	100	0	0	0	0
Northern Territory	0	0	0	0	0	0	0	0	0	10	0	10	0	0	0	0
Australian Capital Territory	0	0	0	0	0	0	0	0	0	40	5	50	0	0	0	0
Other Australian Territories or Dependencies	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Overseas	0	0	0	0	0	0	0	0	0	605	15	625	0	0	0	0
Not known	0	0	0	0	0	0	0	0	0	30	0	30	0	0	0	0
Total	0	0	0	0	0	0	0	0	135	6,250	115	6,500	0	0	0	0

	HLT61107 - Advanced Diploma of Nursing (Enrolled/ Division 2 nursing)				**HLT64115 - Advanced Diploma of Nursing**				**Total**			
New South Wales	0	15	0	15	0	0	0	0	45	1000	15	1,055
Victoria	0	25	0	25	0	0	0	0	15	1,950	15	1,980
Queensland	0	10	0	15	0	0	0	0	40	1,240	45	1,325
South Australia	0	45	0	45	0	0	0	0	5	755	0	760
Western Australia	0	10	5	15	0	0	0	0	20	630	25	670
Tasmania	0	10	0	10	0	0	0	0	10	105	0	110
Northern Territory	0	0	0	0	0	0	0	0	0	10	0	10
Australian Capital Territory	0	0	0	0	0	0	0	0	0	40	5	50
Other Australian Territories or Dependencies	0	0	0	0	0	0	0	0	0	0	0	0
Overseas	0	20	0	20	0	0	0	0	0	630	15	645
Not known	0	0	0	0	0	0	0	0	0	30	0	30
Total	5	135	10	145	0	0	0	0	135	6,385	125	6,645

Source: National VET Provider Collection 2017 and National VET in Schools Collection 2017

Table 5.4: Program completions by Students status, State/territory of residence, Type of accreditation and Indigenous status

Year 2017																
Type of Accreditation	**HLT43407 - Certificate IV in Nursing (Enrolled/ Division 2 nursing)**				**HLT51607 - Diploma of Nursing (Enrolled/ Division 2 nursing)**				**HLT51612 - Diploma of Nursing (Enrolled-Division 2 nursing)**				**HLT54115 - Diploma of Nursing**			
Indigenous status	Indigenous	Non-Indigenous	Not Known	Total	Indigenous	Non-Indigenous	Not Known	Total	Indigenous	Non-Indigenous	Not Known	Total	Indigenous	Non-Indigenous	Not Known	Total
State/territory of residence																
New South Wales	0	0	0	0	0	0	0	0	40	875	15	930	0	15	0	15
Victoria	0	0	0	0	0	0	0	0	15	2,185	15	2,215	0	20	0	20
Queensland	0	0	0	0	0	0	0	0	35	1,400	75	1,510	0	65	5	70
South Australia	0	0	0	0	0	0	0	0	5	430	5	440	0	0	0	0
Western Australia	0	0	0	0	0	0	0	0	25	575	10	610	0	0	0	0
Tasmania	0	0	0	0	0	0	0	0	5	150	0	155	0	0	0	0
Northern Territory	0	0	0	0	0	0	0	0	0	20	0	20	0	0	0	0
Australian Capital Territory	0	0	0	0	0	0	0	0	0	55	10	65	0	0	0	0
Other Australian Territories or Dependencies	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Overseas	0	0	0	0	0	0	0	0	0	740	10	750	0	30	0	30
Not known	0	0	0	0	0	0	0	0	0	25	0	30	0	0	0	0
Total	0	0	0	0	0	0	0	0	130	6,460	135	6,725	5	125	5	135

	HLT61107 - Advanced Diploma of Nursing (Enrolled/ Division 2 nursing)				**HLT64115 - Advanced Diploma of Nursing**				**Total**			
New South Wales	0	15	0	15	0	0	0	0	40	905	15	965
Victoria	0	15	0	15	0	0	0	0	15	2,220	15	2,250
Queensland	0	20	0	25	0	0	0	0	35	1,485	80	1,600
South Australia	0	10	0	10	0	0	0	0	5	440	5	450
Western Australia	0	0	0	0	0	0	0	0	25	580	10	610
Tasmania	0	0	0	0	0	0	0	0	5	150	0	155
Northern Territory	0	0	0	0	0	0	0	0	0	20	0	25
Australian Capital Territory	0	0	0	0	0	0	0	0	0	55	10	65
Other Australian Territories or Dependencies	0	0	0	0	0	0	0	0	0	0	0	0
Overseas	0	15	0	15	0	0	0	0	0	780	10	790
Not known	0	0	0	0	0	0	0	0	0	25	0	30
Total	0	75	0	80	0	0	0	0	135	6,660	145	6,940

Source: National VET Provider Collection 2017 and National VET in Schools Collection 2017

PART 6 - NHWDS DATA RE FIRST TIME REGISTRATIONS

Table 6.1: First year of registration by country of first qualification, All nurses and midwives, 2014-17

	2014	2015	2016	2017
Initial qualification country in nursing or midwifery				
Australia	12,018	11,823	13,692	14,073
Other	3,115	1,775	2,516	3,254
Not stated/inadequately described	3,476	4,427	4,361	4,485
All	**18,609**	**18,025**	**20,569**	**21,812**

Not stated/inadequately described includes non-respondents to the survey

Table 6.2: First year of registration by country of first qualification, All employed nurses and midwives, 2014-17

	2014	2015	2016	2017
Initial qualification country in nursing or midwifery				
Australia	9,518	9,336	10,849	11,017
Other	1,670	1,105	1,549	1,937
Not stated/inadequately described	2,697	3,476	3,216	3,195
All	**13,885**	**13,917**	**15,614**	**16,149**

Not stated/inadequately described includes non-respondents to the survey

Table 6.3: First year of registration for registered nurses by country of first qualification, 2014-17

	2014	2015	2016	2017
Initial qualification country in nursing or midwifery				
Australia	8,230	8,244	9,502	9,762
Other	2,956	1,681	2,409	3,140
Not stated/inadequately described	2,002	2,801	2,652	2,890
All	**13,188**	**12,726**	**14,563**	**15,792**

Not stated/inadequately described includes non-respondents to the survey

Table 6.4: First year of registration for employed registered nurses by country of first qualification, 2014-17

	2014	2015	2016	2017
Initial qualification country in nursing or midwifery				
Australia	6,591	6,664	7,832	7,966
Other	1,558	1,044	1,475	1,854
Not stated/inadequately described	1,470	2,165	1,852	1,968
All	**9,619**	**9,873**	**11,159**	**11,788**

Not stated/inadequately described includes non-respondents to the survey

Table 6.5: First year of registration for all registered midwives (regardless of whether working in midwifery) by country of first qualification, 2014-17

	2014	2015	2016	2017
Initial qualification country in nursing or midwifery				
Australia	499	515	561	700
Other	141	67	79	79
Not stated/inadequately described	64	128	113	113
All	**704**	**710**	**753**	**892**

Not stated/inadequately described includes non-respondents to the survey

Table 6.6: First year of registration for midwives working in midwifery by country of first qualification, 2014-17

	2014	2015	2016	2017
Initial qualification country in nursing or midwifery				
Australia	451	468	490	591
Other	107	48	56	61
Not stated/inadequately described	47	101	71	74
All	**605**	**617**	**617**	**726**

Not stated/inadequately described includes non-respondents to the survey

Table 6.7: First year of registration for enrolled nurses by country of first qualification, 2014-17

	2014	2015	2016	2017
Initial qualification country in nursing or midwifery				
Australia	3,452	3,267	3,811	3,889
Other	46	38	46	44
Not stated/inadequately described	1,426	1,544	1,639	1,518
All	**4,924**	**4,849**	**5,496**	**5,451**

Not stated/inadequately described includes non-respondents to the survey

Table 6.8: First year of registration for employed enrolled nurses by country of first qualification, 2014-17

	2014	2015	2016	2017
Initial qualification country in nursing or midwifery				
Australia	2,618	2,380	2,685	2,700
Other	26	22	30	28
Not stated/inadequately described	1,191	1,248	1,319	1,181
All	**3,835**	**3,650**	**4,034**	**3,909**

Not stated/inadequately described includes non-respondents to the survey
Source: NHWDS Nursing and Midwifery Practitioners, 2013-2017

PART 7 - NEW REGISTRANTS BY WORKFORCE STATUS – NHWDS DATA RE FIRST TIME REGISTRATIONS

Table 7.1: Australian new registrants by workforce status, Nurses and Midwives, 2014

Year 2014	State								
Type of accreditation	**NSW**	**Vic**	**Qld**	**WA**	**SA**	**Tas**	**ACT**	**NT**	**Australia**
In the nursing and midwifery workforce	4,619	4,571	3,445	1,724	1,545	358	241	202	16,705
Employed in nursing or midwifery	3,956	3,848	2,808	1,374	1,187	315	215	177	13,880
On extended leave	84	97	65	32	35	10	3	np	328
Looking for work in nursing or midwifery	579	626	572	318	323	33	23	23	2,497
Employed elsewhere	188	246	250	123	161	13	5	15	1,001
Not employed	391	380	322	195	162	20	18	8	1,496
Not in the nursing or midwifery workforce	325	325	213	181	78	14	15	14	1,165
Overseas	142	125	70	74	23	np	8	5	449
Not looking for work in nursing or midwifery	172	189	134	104	51	12	7	9	678
Employed elsewhere	90	97	77	58	20	7	5	4	358
Not employed	82	92	57	46	31	5	np	5	320
Retired from regular work	11	11	9	3	4	0	0	0	38
Total nurses and midwives	**4,944**	**4,896**	**3,658**	**1,905**	**1,623**	**372**	**256**	**216**	**17,870**

Source: NHWDS Nursing and Midwifery Practitioners, 2014-2015; Results exclude non-respondents and residents of Other Australian Territories; For further information on these tables, refer to the 'Notes' sheet

Table 7.2: Australian new registrants by workforce status, Nurses and Midwives, 2015

Year 2015	State								
Type of accreditation	**NSW**	**Vic**	**Qld**	**WA**	**SA**	**Tas**	**ACT**	**NT**	**Australia**
In the nursing and midwifery workforce	4,514	4,186	3,706	1,804	1,507	335	227	188	16,467
Employed in nursing or midwifery	3,928	3,601	3,137	1,498	1,075	303	211	162	13,915
On extended leave	91	102	87	24	20	np	5	6	336
Looking for work in nursing or midwifery	495	483	482	282	412	31	11	20	2,216
Employed elsewhere	205	205	223	159	219	15	np	11	1,039
Not employed	290	278	259	123	193	16	9	9	1,177
Not in the nursing or midwifery workforce	250	276	182	135	60	11	13	14	941
Overseas	51	46	39	33	11	np	5	6	193
Not looking for work in nursing or midwifery	182	224	138	101	46	9	8	8	716
Employed elsewhere	103	117	77	51	27	4	5	6	390
Not employed	79	107	61	50	19	5	3	np	326
Retired from regular work	17	6	5	np	3	0	0	0	32
Total nurses and midwives	**4,764**	**4,462**	**3,888**	**1,939**	**1,567**	**346**	**240**	**202**	**17,408**

Source: NHWDS Nursing and Midwifery Practitioners, 2014-2015; Results exclude non-respondents and residents of Other Australian Territories; For further information on these tables, refer to the 'Notes' sheet

Table 7.3: Australian new registrants by workforce status, Nurses and Midwives, 2016

Year 2016	State								
Type of accreditation	**NSW**	**Vic**	**Qld**	**WA**	**SA**	**Tas**	**ACT**	**NT**	**Australia**
In the nursing and midwifery workforce	5,332	4,870	4,073	1,810	1,588	357	323	221	18,574
Employed in nursing or midwifery	4,575	4,214	3,478	1,452	1,096	316	286	190	15,607
On extended leave	93	88	65	54	30	3	3	np	337
Looking for work in nursing or midwifery	664	568	530	304	462	38	34	30	2,630
Employed elsewhere	285	273	268	164	275	20	22	20	1,327
Not employed	379	295	262	140	187	18	12	10	1,303
Not in the nursing or midwifery workforce	247	366	242	136	93	17	23	16	1,140
Overseas	83	105	93	48	17	3	6	3	358
Not looking for work in nursing or midwifery	150	254	147	84	71	14	16	12	748
Employed elsewhere	72	146	77	49	34	6	6	8	398
Not employed	78	108	70	35	37	8	10	4	350
Retired from regular work	14	7	np	4	5	0	np	np	34
Total nurses and midwives	**5,579**	**5,236**	**4,315**	**1,946**	**1,681**	**374**	**346**	**237**	**19,714**

Source: NHWDS Nursing and Midwifery Practitioners, 2014-2015; Results exclude non-respondents and residents of Other Australian Territories; For further information on these tables, refer to the 'Notes' sheet

Table 7.4: Australian new registrants by workforce status, Nurses and Midwives, 2017

Year 2017	State								
Type of accreditation	**NSW**	**Vic**	**Qld**	**WA**	**SA**	**Tas**	**ACT**	**NT**	**Australia**
In the nursing and midwifery workforce	5,600	5,213	4,166	1,833	1,555	406	375	224	19,372
Employed in nursing or midwifery	4,857	4,404	3,452	1,456	1,074	375	330	190	16,138
On extended leave	91	106	74	40	49	3	5	3	371
Looking for work in nursing or midwifery	652	703	640	337	432	28	40	31	2,863
Employed elsewhere	297	366	317	191	269	9	20	19	1,488
Not employed	355	337	323	146	163	19	20	12	1,375
Not in the nursing or midwifery workforce	383	446	266	151	108	26	27	17	1,424
Overseas	106	115	58	42	10	4	7	10	352
Not looking for work in nursing or midwifery	272	323	205	109	95	22	20	7	1,053
Employed elsewhere	163	206	111	73	61	14	14	3	645
Not employed	109	117	94	36	34	8	6	4	408
Retired from regular work	5	8	3	0	3	0	0	0	19
Total nurses and midwives	**5,983**	**5,659**	**4,432**	**1,984**	**1,663**	**432**	**402**	**241**	**20,796**

Source: NHWDS Nursing and Midwifery Practitioners, 2014-2015; Results exclude non-respondents and residents of Other Australian Territories; For further information on these tables, refer to the 'Notes' sheet

Table 7.5: Australian new registrants with registered nurse division registration by workforce status, 2014

Year 2014	State								
Type of accreditation	**NSW**	**Vic**	**Qld**	**WA**	**SA**	**Tas**	**ACT**	**NT**	**Australia**
In the nursing and midwifery workforce	3,647	3,008	2,183	1,234	948	227	185	173	11,605
Employed in nursing or midwifery	3,096	2,536	1,784	955	725	204	163	153	9,616
On extended leave	65	47	42	22	19	6	3	np	205
Looking for work in nursing or midwifery	486	425	357	257	204	17	19	19	1,784
Employed elsewhere	152	146	152	101	85	7	3	12	658
Not employed	334	279	205	156	119	10	16	7	1,126
Not in the nursing or midwifery workforce	284	206	140	144	62	10	12	13	871
Overseas	137	120	66	66	22	np	7	5	425
Not looking for work in nursing or midwifery	136	78	70	76	37	8	5	8	418
Employed elsewhere	74	41	36	43	13	6	4	4	221
Not employed	62	37	34	33	24	np	np	4	197
Retired from regular work	11	8	4	np	3	0	0	0	28
Total nurses and midwives	**3,931**	**3,214**	**2,323**	**1,378**	**1,010**	**237**	**197**	**186**	**12,476**

Source: NHWDS Nursing and Midwifery Practitioners, 2014-2015; Results exclude non-respondents and residents of Other Australian Territories; For further information on these tables, refer to the 'Notes' sheet

Table 7.6: Australian new registrants with registered nurse division registration by workforce status, 2015

Year 2015	State								
Type of accreditation	**NSW**	**Vic**	**Qld**	**WA**	**SA**	**Tas**	**ACT**	**NT**	**Australia**
In the nursing and midwifery workforce	3,510	2,733	2,474	1,266	967	250	166	156	11,522
Employed in nursing or midwifery	3,058	2,426	2,134	1,071	667	224	156	135	9,871
On extended leave	71	57	51	20	13	np	3	6	222
Looking for work in nursing or midwifery	381	250	289	175	287	25	7	15	1,429
Employed elsewhere	154	103	133	100	154	11	np	10	666
Not employed	227	147	156	75	133	14	6	5	763
Not in the nursing or midwifery workforce	200	131	118	102	41	6	12	7	617
Overseas	49	42	35	29	10	np	4	6	177
Not looking for work in nursing or midwifery	135	88	81	72	29	4	8	np	418
Employed elsewhere	75	40	48	35	15	np	5	0	220
Not employed	60	48	33	37	14	np	3	np	198
Retired from regular work	16	np	np	np	np	0	0	0	22
Total nurses and midwives	**3,710**	**2,864**	**2,592**	**1,368**	**1,008**	**256**	**178**	**163**	**12,139**

Source: NHWDS Nursing and Midwifery Practitioners, 2014-2015; Results exclude non-respondents and residents of Other Australian Territories; For further information on these tables, refer to the 'Notes' sheet

Table 7.7: Australian new registrants with registered nurse division registration by workforce status, 2016

Year 2016	State								
Type of accreditation	**NSW**	**Vic**	**Qld**	**WA**	**SA**	**Tas**	**ACT**	**NT**	**Australia**
In the nursing and midwifery workforce	4,151	3,178	2,721	1,338	905	265	252	179	12,989
Employed in nursing or midwifery	3,597	2,831	2,399	1,085	626	243	221	151	11,153
On extended leave	66	47	44	37	14	np	np	0	211
Looking for work in nursing or midwifery	488	300	278	216	265	21	29	28	1,625
Employed elsewhere	205	140	144	114	145	9	18	18	793
Not employed	283	160	134	102	120	12	11	10	832
Not in the nursing or midwifery workforce	199	190	163	95	55	14	17	13	746
Overseas	70	94	82	44	14	3	4	3	314
Not looking for work in nursing or midwifery	117	95	79	49	36	11	12	9	408
Employed elsewhere	58	54	41	30	17	5	6	5	216
Not employed	59	41	38	19	19	6	6	4	192
Retired from regular work	12	np	np	np	5	0	np	np	24
Total nurses and midwives	**4,350**	**3,368**	**2,884**	**1,433**	**960**	**279**	**269**	**192**	**13,735**

Source: NHWDS Nursing and Midwifery Practitioners, 2014-2015; Results exclude non-respondents and residents of Other Australian Territories; For further information on these tables, refer to the 'Notes' sheet

Table 7.8: Australian new registrants with registered nurse division registration by workforce status, 2017

Year 2017	State								
Type of accreditation	**NSW**	**Vic**	**Qld**	**WA**	**SA**	**Tas**	**ACT**	**NT**	**Australia**
In the nursing and midwifery workforce	4,418	3,534	2,802	1,365	941	288	284	186	13,818
Employed in nursing or midwifery	3,866	3,056	2,411	1,110	661	270	247	156	11,777
On extended leave	65	62	46	32	26	np	3	3	238
Looking for work in nursing or midwifery	487	416	345	223	254	17	34	27	1,803
Employed elsewhere	207	189	183	127	138	4	18	19	885
Not employed	280	227	162	96	116	13	16	8	918
Not in the nursing or midwifery workforce	300	291	170	117	57	23	21	14	993
Overseas	99	111	52	41	9	4	7	9	332
Not looking for work in nursing or midwifery	196	173	115	76	46	19	14	5	644
Employed elsewhere	109	111	65	53	33	12	8	np	393
Not employed	87	62	50	23	13	7	6	3	251
Retired from regular work	5	7	3	0	np	0	0	0	17
Total nurses and midwives	**4,718**	**3,825**	**2,972**	**1,482**	**998**	**311**	**305**	**200**	**14,811**

Source: NHWDS Nursing and Midwifery Practitioners, 2014-2015; Results exclude non-respondents and residents of Other Australian Territories; For further information on these tables, refer to the 'Notes' sheet

Table 7.9: Australian new registrants with enrolled nurse division registration by workforce status, 2014

Year 2014	State								
Type of accreditation	**NSW**	**Vic**	**Qld**	**WA**	**SA**	**Tas**	**ACT**	**NT**	**Australia**
In the nursing and midwifery workforce	817	1,467	1,162	460	541	131	39	19	4,636
Employed in nursing or midwifery	710	1,223	937	390	412	111	35	15	3,833
On extended leave	18	48	23	10	15	4	0	np	119
Looking for work in nursing or midwifery	89	196	202	60	114	16	4	3	684
Employed elsewhere	36	99	94	23	77	6	np	3	340
Not employed	53	97	108	37	37	10	np	0	344
Not in the nursing or midwifery workforce	38	115	69	31	15	4	np	np	275
Overseas	3	4	3	np	np	0	np	0	14
Not looking for work in nursing or midwifery	35	108	61	28	13	4	np	np	251
Employed elsewhere	16	56	38	15	6	np	np	0	133
Not employed	19	52	23	13	7	3	0	np	118
Retired from regular work	0	3	5	np	np	0	0	0	10
Total nurses and midwives	**855**	**1,582**	**1,231**	**491**	**556**	**135**	**41**	**20**	**4,911**

Source: NHWDS Nursing and Midwifery Practitioners, 2014-2015; Results exclude non-respondents and residents of Other Australian Territories; For further information on these tables, refer to the 'Notes' sheet

Table 7.10: Australian new registrants with enrolled nurse division registration by workforce status, 2015

Year 2015	State								
Type of accreditation	**NSW**	**Vic**	**Qld**	**WA**	**SA**	**Tas**	**ACT**	**NT**	**Australia**
In the nursing and midwifery workforce	888	1,362	1,132	506	503	79	40	23	4,533
Employed in nursing or midwifery	758	1,088	911	396	372	73	34	18	3,650
On extended leave	19	43	32	4	7	0	np	0	107
Looking for work in nursing or midwifery	111	231	189	106	124	6	4	5	776
Employed elsewhere	49	102	90	59	67	4	np	np	373
Not employed	62	129	99	47	57	np	3	4	403
Not in the nursing or midwifery workforce	47	137	62	29	17	5	0	6	303
Overseas	0	4	4	np	np	0	0	0	10
Not looking for work in nursing or midwifery	46	128	55	28	15	5	0	6	283
Employed elsewhere	27	74	29	16	10	np	0	6	164
Not employed	19	54	26	12	5	3	0	0	119
Retired from regular work	np	5	3	0	np	0	0	0	10
Total nurses and midwives	**935**	**1,499**	**1,194**	**535**	**520**	**84**	**40**	**29**	**4,836**

Source: NHWDS Nursing and Midwifery Practitioners, 2014-2015; Results exclude non-respondents and residents of Other Australian Territories; For further information on these tables, refer to the 'Notes' sheet

Table 7.11: Australian new registrants with enrolled nurse division registration by workforce status, 2016

Year 2016	State								
Type of accreditation	**NSW**	**Vic**	**Qld**	**WA**	**SA**	**Tas**	**ACT**	**NT**	**Australia**
In the nursing and midwifery workforce	1,052	1,601	1,247	427	633	91	55	27	5,133
Employed in nursing or midwifery	853	1,298	983	324	430	72	49	24	4,033
On extended leave	26	39	21	17	16	np	np	np	123
Looking for work in nursing or midwifery	173	264	243	86	187	17	5	np	977
Employed elsewhere	79	132	120	49	124	11	4	np	521
Not employed	94	132	123	37	63	6	np	0	456
Not in the nursing or midwifery workforce	38	161	76	40	33	3	3	3	357
Overseas	6	9	10	3	np	0	0	0	30
Not looking for work in nursing or midwifery	30	147	66	35	31	3	3	3	318
Employed elsewhere	14	88	35	19	15	np	0	3	175
Not employed	16	59	31	16	16	np	3	0	143
Retired from regular work	np	5	0	np	0	0	0	0	9
Total nurses and midwives	**1,090**	**1,762**	**1,323**	**467**	**666**	**94**	**58**	**30**	**5,490**

Source: NHWDS Nursing and Midwifery Practitioners, 2014-2015; Results exclude non-respondents and residents of Other Australian Territories; For further information on these tables, refer to the 'Notes' sheet

Table 7.12: Australian new registrants with enrolled nurse division registration by workforce status, 2017

Year 2017	State								
Type of accreditation	**NSW**	**Vic**	**Qld**	**WA**	**SA**	**Tas**	**ACT**	**NT**	**Australia**
In the nursing and midwifery workforce	1,015	1,595	1,233	435	547	116	74	25	5,040
Employed in nursing or midwifery	830	1,272	937	313	363	103	68	23	3,909
On extended leave	26	42	27	8	21	np	np	0	128
Looking for work in nursing or midwifery	159	281	269	114	163	11	4	np	1,003
Employed elsewhere	88	174	126	64	127	5	np	0	585
Not employed	71	107	143	50	36	6	3	np	418
Not in the nursing or midwifery workforce	76	146	87	33	46	3	5	np	398
Overseas	np	np	4	0	np	0	0	0	8
Not looking for work in nursing or midwifery	74	144	83	33	44	3	5	np	388
Employed elsewhere	54	93	43	20	25	np	5	np	243
Not employed	20	51	40	13	19	np	0	np	145
Retired from regular work	0	np	0	0	np	0	0	0	np
Total nurses and midwives	**1,091**	**1,741**	**1,320**	**468**	**593**	**119**	**79**	**27**	**5,438**

Source: NHWDS Nursing and Midwifery Practitioners, 2014-2015; Results exclude non-respondents and residents of Other Australian Territories; For further information on these tables, refer to the 'Notes' sheet

Table 7.13: Australian new registrants with midwife registration by workforce status, 2014

Year 2014	State								
Type of accreditation	**NSW**	**Vic**	**Qld**	**WA**	**SA**	**Tas**	**ACT**	**NT**	**Australia**
In the nursing and midwifery workforce	174	182	154	49	65	np	18	15	658
Employed in nursing or midwifery	167	170	136	45	56	np	18	12	605
On extended leave	np	np	3	0	np	0	0	0	8
Looking for work in nursing or midwifery	5	10	15	4	8	0	0	3	45
Employed elsewhere	0	5	6	0	np	0	0	0	13
Not employed	5	5	9	4	6	0	0	3	32
Not in the nursing or midwifery workforce	8	6	6	7	np	0	np	0	29
Overseas	3	np	np	6	0	0	0	0	12
Not looking for work in nursing or midwifery	5	5	4	np	np	0	np	0	17
Employed elsewhere	3	np	4	0	np	0	0	0	9
Not employed	np	4	0	np	0	0	np	0	8
Retired from regular work	0	0	0	0	0	0	0	0	0
Total nurses and midwives	**182**	**188**	**160**	**56**	**66**	**np**	**19**	**15**	**687**

Source: NHWDS Nursing and Midwifery Practitioners, 2014-2015; Results exclude non-respondents and residents of Other Australian Territories; For further information on these tables, refer to the 'Notes' sheet

Table 7.14: Australian new registrants with midwife registration by workforce status, 2015

Year 2015	State								
Type of accreditation	**NSW**	**Vic**	**Qld**	**WA**	**SA**	**Tas**	**ACT**	**NT**	**Australia**
In the nursing and midwifery workforce	125	205	176	52	53	6	22	14	653
Employed in nursing or midwifery	120	195	163	49	48	6	22	14	617
On extended leave	np	4	7	np	0	0	0	0	13
Looking for work in nursing or midwifery	4	6	6	np	5	0	0	0	23
Employed elsewhere	np	4	0	0	0	0	0	0	6
Not employed	np	np	6	np	5	0	0	0	17
Not in the nursing or midwifery workforce	5	16	5	5	np	0	np	np	35
Overseas	3	0	0	3	0	0	np	0	7
Not looking for work in nursing or midwifery	np	16	5	np	np	0	0	np	28
Employed elsewhere	np	9	np	0	np	0	0	0	14
Not employed	0	7	4	np	0	0	0	np	14
Retired from regular work	0	0	0	0	0	0	0	0	0
Total nurses and midwives	**130**	**221**	**181**	**57**	**55**	**6**	**23**	**15**	**688**

Source: NHWDS Nursing and Midwifery Practitioners, 2014-2015; Results exclude non-respondents and residents of Other Australian Territories; For further information on these tables, refer to the 'Notes' sheet

Table 7.15: Australian new registrants with midwife registration by workforce status, 2016

Year 2016	State								
Type of accreditation	**NSW**	**Vic**	**Qld**	**WA**	**SA**	**Tas**	**ACT**	**NT**	**Australia**
In the nursing and midwifery workforce	133	210	168	61	59	np	20	17	670
Employed in nursing or midwifery	128	196	153	56	45	np	20	17	616
On extended leave	np	np	3	np	0	0	0	0	7
Looking for work in nursing or midwifery	4	12	12	4	14	np	0	0	47
Employed elsewhere	np	6	5	np	7	np	0	0	22
Not employed	np	6	7	3	7	0	0	0	25
Not in the nursing or midwifery workforce	14	20	9	np	6	0	3	0	53
Overseas	7	4	4	np	np	0	np	0	19
Not looking for work in nursing or midwifery	6	15	5	0	5	0	np	0	32
Employed elsewhere	np	5	np	0	np	0	0	0	10
Not employed	5	10	3	0	3	0	np	0	22
Retired from regular work	np	np	0	0	0	0	0	0	np
Total nurses and midwives	**147**	**230**	**177**	**62**	**65**	**np**	**23**	**17**	**723**

Source: NHWDS Nursing and Midwifery Practitioners, 2014-2015; Results exclude non-respondents and residents of Other Australian Territories; For further information on these tables, refer to the 'Notes' sheet

Table 7.16: Australian new registrants with midwife registration by workforce status, 2017

Year 2017	State								
Type of accreditation	**NSW**	**Vic**	**Qld**	**WA**	**SA**	**Tas**	**ACT**	**NT**	**Australia**
In the nursing and midwifery workforce	178	241	234	50	78	4	17	17	819
Employed in nursing or midwifery	172	226	191	49	55	4	15	14	726
On extended leave	0	5	np	np	np	0	0	0	10
Looking for work in nursing or midwifery	6	10	41	0	21	0	np	3	83
Employed elsewhere	np	5	17	0	5	0	np	np	31
Not employed	4	5	24	0	16	0	np	np	52
Not in the nursing or midwifery workforce	10	17	13	np	5	0	np	np	49
Overseas	5	3	4	np	0	0	0	np	14
Not looking for work in nursing or midwifery	5	14	9	0	5	0	np	np	35
Employed elsewhere	3	5	3	0	3	0	np	np	16
Not employed	np	9	6	0	np	0	0	0	19
Retired from regular work	0	0	0	0	0	0	0	0	0
Total nurses and midwives	**188**	**258**	**247**	**51**	**83**	**4**	**18**	**19**	**868**

Source: NHWDS Nursing and Midwifery Practitioners, 2014-2015; Results exclude non-respondents and residents of Other Australian Territories; For further information on these tables, refer to the 'Notes' sheet

PART 8 - EMPLOYED NEW REGISTRANTS WHERE INITIAL QUALIFICATION IN AUSTRALIA

Employed new registrants - All Nurses and Midwives

Table 8.1: Employed new registrants in Australia where initial qualification in Australia, by State, Selected statistics, registered midwives with midwifery hours, 2014-17

Australia				
	2014	**2015**	**2016**	**2017**
Number Employed	9,517	9,336	10,848	11,017
Average weekly hours worked	34.2	34.3	34.3	33.7
FTE	8,554.2	8,428.2	9,796.3	9,782.7
FTE rate	290.0	289.3	336.2	327.9
Number with public sector hours	5,929	5,945	6,884	7,049
Number with private sector hours	3,859	3,634	4,215	4,226
Part time (percent)	54.1	54.9	54.5	58.9
Women (percent)	89.5	89.1	88.1	88.4
Indigenous (percent)	1.7	1.9	2.0	2.3
Age Group				
Aged <25 (number)	4,210	4,211	4,780	4,970
Aged 25–34 (number)	2,829	2,926	3,514	3,575
Aged 35–44 (number)	1,488	1,347	1,604	1,539
Aged 45–54 (number)	801	689	780	771
Aged 55+ (number)	189	163	170	162
Remoteness area				
Number in Major cities	6,977	6,888	7,961	7,928
Number in Inner regional areas	1,675	1,583	1,853	1,955
Number in Outer regional areas	736	719	863	926
Number in Remote/Very remote areas	129	146	171	208
Number in unknown/overseas areas	0	0	0	0

Source: NHWDS Nursing and Midwifery Practitioners, 2013-2017

For further information on these tables, refer to the 'Notes' sheet

Table 8.2: Employed new registrants in Australia where initial qualification in Australia, by State, Selected statistics - All Nurses and Midwives, New South Wales, 2014-17

New South Wales				
	2014	**2015**	**2016**	**2017**
Number Employed	2,743	2,676	3,164	3,323
Average weekly hours worked	36.4	36.4	36.4	36.3
FTE	2,630.2	2,565.8	3,034.6	3,178.2
FTE rate	35.0	33.6	39.2	40.4
Number with public sector hours	1,831	1,769	2,085	2,244
Number with private sector hours	975	973	1,135	1,134
Part time (percent)	33.0	31.9	31.9	32.6
Women (percent)	87.0	86.4	84.8	86.1
Indigenous (percent)	2.2	2.8	2.5	3.0
Age Group				
Aged <25 (number)	1,141	1,108	1,266	1,364
Aged 25–34 (number)	922	924	1,122	1,203
Aged 35–44 (number)	418	385	497	484
Aged 45–54 (number)	216	217	230	223
Aged 55+ (number)	46	42	49	49
Remoteness area				
Number in Major cities	2,123	2,082	2,420	2,542
Number in Inner regional areas	503	475	598	598
Number in Outer regional areas	108	110	125	158
Number in Remote/Very remote areas	9	9	21	25
Number in unknown/overseas areas	0	0	0	0

Source: NHWDS Nursing and Midwifery Practitioners, 2013-2017

For further information on these tables, refer to the 'Notes' sheet

Table 8.3: Employed new registrants in Australia where initial qualification in Australia, by State, Selected statistics, All Nurses and Midwives, Victoria, 2014-17

Victoria				
	2014	**2015**	**2016**	**2017**
Number Employed	2,664	2,419	2,865	2,974
Average weekly hours worked	33.5	32.8	32.7	31.8
FTE	2,346.2	2,090.0	2,463.4	2,492.2
FTE rate	39.8	34.6	39.9	39.4
Number with public sector hours	1,700	1,627	1,854	1,941
Number with private sector hours	1,061	845	1,095	1,121
Part time (percent)	61.3	67.0	66.5	75.9
Women (percent)	90.8	90.5	88.7	89.2
Indigenous (percent)	0.7	0.8	0.7	1.3
Age Group				
Aged <25 (number)	1,378	1,247	1,473	1,549
Aged 25–34 (number)	718	713	870	895
Aged 35–44 (number)	337	275	342	343
Aged 45–54 (number)	180	138	151	153
Aged 55+ (number)	51	46	29	34
Remoteness area				
Number in Major cities	2,009	1,835	2,190	2,242
Number in Inner regional areas	544	489	552	592
Number in Outer regional areas	110	94	122	139
Number in Remote/Very remote areas	np	np	np	np
Number in unknown/overseas areas	0	0	0	0

Source: NHWDS Nursing and Midwifery Practitioners, 2013-2017
For further information on these tables, refer to the 'Notes' sheet

Table 8.4: Employed new registrants in Australia where initial qualification in Australia, by State, Selected statistics - All Nurses and Midwives, Queensland, 2014-17

Queensland				
	2014	2015	2016	2017
Number Employed	1,972	2,144	2,550	2,419
Average weekly hours worked	32.2	33.3	33.6	32.9
FTE	1,671.3	1,878.7	2,254.5	2,093.3
FTE rate	35.4	39.3	46.5	42.5
Number with public sector hours	1,100	1,290	1,582	1,416
Number with private sector hours	928	912	1,034	1,058
Part time (percent)	69.6	66.3	65.0	71.6
Women (percent)	91.1	89.9	89.7	89.2
Indigenous (percent)	2.4	1.6	2.5	2.5
Age Group				
Aged <25 (number)	786	906	1,026	1,066
Aged 25–34 (number)	563	657	828	764
Aged 35–44 (number)	382	361	406	354
Aged 45–54 (number)	194	181	230	197
Aged 55+ (number)	47	39	60	38
Remoteness area				
Number in Major cities	1,299	1,463	1,761	1,567
Number in Inner regional areas	341	340	382	427
Number in Outer regional areas	285	290	351	347
Number in Remote/Very remote areas	47	51	56	78
Number in unknown/overseas areas	0	0	0	0

Source: NHWDS Nursing and Midwifery Practitioners, 2013-2017
For further information on these tables, refer to the 'Notes' sheet

Table 8.5: Employed new registrants in Australia where initial qualification in Australia, by State, Selected statistics - All Nurses and Midwives, Western Australia, 2014-17

Western Australia				
	2014	**2015**	**2016**	**2017**
Number Employed	866	880	923	947
Average weekly hours worked	35.5	36.1	35.5	34.3
FTE	810.1	836.4	862.4	854.8
FTE rate	32.1	32.9	33.7	33.1
Number with public sector hours	513	486	495	582
Number with private sector hours	371	413	442	391
Part time (percent)	52.3	56.3	58.0	60.3
Women (percent)	91.9	92.2	93.6	92.6
Indigenous (percent)	1.6	2.1	2.3	2.2
Age Group				
Aged <25 (number)	388	425	440	433
Aged 25–34 (number)	238	246	271	260
Aged 35–44 (number)	135	136	145	151
Aged 45–54 (number)	83	62	58	84
Aged 55+ (number)	22	11	9	19
Remoteness area				
Number in Major cities	735	757	791	767
Number in Inner regional areas	54	52	46	63
Number in Outer regional areas	54	42	56	70
Number in Remote/Very remote areas	23	29	30	47
Number in unknown/overseas areas	0	0	0	0

Source: NHWDS Nursing and Midwifery Practitioners, 2013-2017

For further information on these tables, refer to the 'Notes' sheet

Table 8.6: Employed new registrants in Australia where initial qualification in Australia, by State, Selected statistics - All Nurses and Midwives, South Australia, 2014-17

South Australia				
	2014	**2015**	**2016**	**2017**
Number Employed	812	738	744	742
Average weekly hours worked	31.8	31.7	32.0	30.9
FTE	680.4	615.4	626.7	603.4
FTE rate	40.3	36.2	36.6	35.0
Number with public sector hours	482	444	450	439
Number with private sector hours	355	326	311	322
Part time (percent)	64.0	64.1	62.9	70.2
Women (percent)	88.7	88.2	88.0	87.5
Indigenous (percent)	1.0	1.9	2.2	1.2
Age Group				
Aged <25 (number)	327	308	321	315
Aged 25–34 (number)	249	245	230	249
Aged 35–44 (number)	142	120	129	111
Aged 45–54 (number)	79	50	55	56
Aged 55+ (number)	15	15	9	11
Remoteness area				
Number in Major cities	672	608	587	605
Number in Inner regional areas	32	34	47	33
Number in Outer regional areas	92	78	94	90
Number in Remote/Very remote areas	16	18	16	14
Number in unknown/overseas areas	0	0	0	0

Source: NHWDS Nursing and Midwifery Practitioners, 2013-2017

For further information on these tables, refer to the 'Notes' sheet

Table 8.7: Employed new registrants in Australia where initial qualification in Australia, by State, Selected statistics - All Nurses and Midwives, Tasmania, 2014-17

Tasmania				
	2014	**2015**	**2016**	**2017**
Number Employed	234	244	281	310
Average weekly hours worked	32.1	33.3	33.0	33.4
FTE	197.6	214.1	244.2	272.1
FTE rate	38.5	41.5	47.2	52.2
Number with public sector hours	122	150	189	205
Number with private sector hours	121	103	101	116
Part time (percent)	76.9	74.2	75.4	72.9
Women (percent)	85.0	92.6	87.9	90.6
Indigenous (percent)	3.9	3.7	1.8	3.6
Age Group				
Aged <25 (number)	96	112	118	117
Aged 25–34 (number)	61	61	73	86
Aged 35–44 (number)	41	39	46	54
Aged 45–54 (number)	34	26	35	48
Aged 55+ (number)	np	6	9	5
Remoteness area				
Number in Major cities	0	0	0	0
Number in Inner regional areas	201	193	228	242
Number in Outer regional areas	33	49	49	63
Number in Remote/Very remote areas	0	np	4	5
Number in unknown/overseas areas	0	0	0	0

Source: NHWDS Nursing and Midwifery Practitioners, 2013-2017
For further information on these tables, refer to the 'Notes' sheet

Table 8.8: Employed new registrants in Australia where initial qualification in Australia, by State, Selected statistics - All Nurses and Midwives, Australian Capital Territory, 2014-17

Australian Capital Territory				
	2014	**2015**	**2016**	**2017**
Number Employed	139	143	212	205
Average weekly hours worked	36.8	37.0	37.4	36.5
FTE	134.6	139.3	208.5	197.1
FTE rate	34.6	35.1	51.7	48.0
Number with public sector hours	109	109	147	146
Number with private sector hours	33	38	67	62
Part time (percent)	33.1	30.1	34.0	29.3
Women (percent)	90.6	85.3	85.4	83.9
Indigenous (percent)	1.4	1.4	1.4	2.5
Age Group				
Aged <25 (number)	62	66	93	94
Aged 25–34 (number)	42	45	77	71
Aged 35–44 (number)	24	20	26	28
Aged 45–54 (number)	9	9	13	8
Aged 55+ (number)	np	np	np	4
Remoteness area				
Number in Major cities	139	143	212	205
Number in Inner regional areas	0	0	0	0
Number in Outer regional areas	0	0	0	0
Number in Remote/Very remote areas	0	0	0	0
Number in unknown/overseas areas	0	0	0	0

Source: NHWDS Nursing and Midwifery Practitioners, 2013-2017
For further information on these tables, refer to the 'Notes' sheet

Table 8.9: Employed new registrants in Australia where initial qualification in Australia, by State, Selected statistics - All Nurses and Midwives, Northern Territory, 2014-17

Northern Territory				
	2014	2015	2016	2017
Number Employed	87	92	109	97
Average weekly hours worked	36.6	36.5	35.6	35.9
FTE	83.9	88.3	102.0	91.6
FTE rate	34.4	36.0	41.5	37.2
Number with public sector hours	72	70	82	76
Number with private sector hours	15	24	30	22
Part time (percent)	49.4	45.7	48.6	46.4
Women (percent)	88.5	89.1	86.2	90.7
Indigenous (percent)	7.0	6.6	3.7	5.2
Age Group				
Aged <25 (number)	32	39	43	32
Aged 25–34 (number)	36	35	43	47
Aged 35–44 (number)	9	11	13	14
Aged 45–54 (number)	6	6	8	np
Aged 55+ (number)	4	np	np	np
Remoteness area				
Number in Major cities	0	0	0	0
Number in Inner regional areas	0	0	0	0
Number in Outer regional areas	54	56	66	59
Number in Remote/Very remote areas	33	36	43	38
Number in unknown/overseas areas	0	0	0	0

Source: NHWDS Nursing and Midwifery Practitioners, 2013-2017

For further information on these tables, refer to the 'Notes' sheet

Employed new registrants - Registered Nurses only

Table 8.10: Employed new registrants in Australia where initial qualification in Australia, Selected statistics, Registered Nurses, Australia, 2014-17

Australia				
	2014	**2015**	**2016**	**2017**
Number Employed	6,590	6,664	7,832	7,966
Average weekly hours worked	35.6	35.7	35.7	35.0
FTE	6,167.2	6,266.6	7,367.2	7,341.3
FTE rate	208.4	213.5	248.3	243.1
Number with public sector hours	4,540	4,599	5,436	5,513
Number with private sector hours	2,186	2,206	2,546	2,586
Part time (percent)	47.1	49.0	48.4	53.7
Women (percent)	89.0	89.0	87.5	88.0
Indigenous (percent)	1.3	1.6	1.4	2.0
Age Group				
Aged <25 (number)	3,376	3,387	3,836	4,080
Aged 25–34 (number)	1,992	2,122	2,583	2,571
Aged 35–44 (number)	818	783	941	897
Aged 45–54 (number)	341	311	394	340
Aged 55+ (number)	63	61	78	78
Remoteness area				
Number in Major cities	4,975	5,019	5,903	5,866
Number in Inner regional areas	1,055	1,058	1,232	1,328
Number in Outer regional areas	465	477	560	616
Number in Remote/Very remote areas	95	110	137	156
Number in unknown/overseas areas	0	0	0	0

Source: NHWDS Nursing and Midwifery Practitioners, 2013-2017

For further information on these tables, refer to the 'Notes' sheet

Table 8.11: Employed new registrants in Australia where initial qualification in Australia, by State, Selected statistics, Registered nurses, New South Wales, 2014-17

New South Wales				
	2014	**2015**	**2016**	**2017**
Number Employed	2,129	2,096	2,525	2,615
Average weekly hours worked	37.1	37.1	37.2	37.1
FTE	2,080.7	2,043.9	2,469.7	2,553.4
FTE rate	27.7	26.8	31.9	32.5
Number with public sector hours	1,478	1,404	1,701	1,788
Number with private sector hours	687	736	862	861
Part time (percent)	27.2	27.7	27.2	27.7
Women (percent)	86.0	86.3	83.7	85.1
Indigenous (percent)	1.5	2.1	1.7	2.5
Age Group				
Aged <25 (number)	970	919	1,069	1,156
Aged 25–34 (number)	738	764	924	963
Aged 35–44 (number)	288	267	357	351
Aged 45–54 (number)	109	120	143	112
Aged 55+ (number)	24	26	32	33
Remoteness area				
Number in Major cities	1,731	1,702	2,005	2,075
Number in Inner regional areas	327	325	416	420
Number in Outer regional areas	64	64	86	102
Number in Remote/Very remote areas	7	5	18	18
Number in unknown/overseas areas	0	0	0	0

Source: NHWDS Nursing and Midwifery Practitioners, 2013-2017

For further information on these tables, refer to the 'Notes' sheet

Table 8.12: Employed new registrants in Australia where initial qualification in Australia, by State, Selected statistics, Registered nurses, Victoria, 2014-17

Victoria				
	2014	2015	2016	2017
Number Employed	1,778	1,663	1,956	2,019
Average weekly hours worked	35.6	35.3	34.9	33.6
FTE	1,668.0	1,543.7	1,797.0	1,784.6
FTE rate	28.3	25.6	29.1	28.2
Number with public sector hours	1,308	1,271	1,457	1,516
Number with private sector hours	511	415	543	538
Part time (percent)	52.5	59.7	59.6	72.8
Women (percent)	89.9	91.3	89.1	89.5
Indigenous (percent)	0.8	0.8	0.6	1.1
Age Group				
Aged <25 (number)	1,093	1,007	1,150	1,236
Aged 25–34 (number)	482	480	580	582
Aged 35–44 (number)	129	119	155	149
Aged 45–54 (number)	60	46	62	39
Aged 55+ (number)	14	11	9	13
Remoteness area				
Number in Major cities	1,403	1,316	1,557	1,595
Number in Inner regional areas	315	290	326	353
Number in Outer regional areas	60	56	72	71
Number in Remote/Very remote areas	0	np	np	0
Number in unknown/overseas areas	0	0	0	0

Source: NHWDS Nursing and Midwifery Practitioners, 2013-2017

For further information on these tables, refer to the 'Notes' sheet

Table 8.13: Employed new registrants in Australia where initial qualification in Australia, by State, Selected statistics, Registered nurses, Queensland, 2014-17

Queensland				
	2014	**2015**	**2016**	**2017**
Number Employed	1,319	1,475	1,781	1,726
Average weekly hours worked	33.0	34.4	34.8	33.9
FTE	1,146.4	1,336.7	1,631.5	1,537.8
FTE rate	24.3	27.9	33.6	31.2
Number with public sector hours	802	970	1,251	1,127
Number with private sector hours	550	540	571	629
Part time (percent)	67.5	63.3	60.9	68.7
Women (percent)	91.9	90.0	88.9	89.3
Indigenous (percent)	1.8	1.8	1.8	2.2
Age Group				
Aged <25 (number)	606	722	814	875
Aged 25–34 (number)	380	442	604	533
Aged 35–44 (number)	224	214	228	205
Aged 45–54 (number)	96	84	112	97
Aged 55+ (number)	13	13	23	16
Remoteness area				
Number in Major cities	831	979	1,237	1,077
Number in Inner regional areas	244	247	263	321
Number in Outer regional areas	208	207	233	262
Number in Remote/Very remote areas	36	42	48	66
Number in unknown/overseas areas	0	0	0	0

Source: NHWDS Nursing and Midwifery Practitioners, 2013-2017
For further information on these tables, refer to the 'Notes' sheet

Table 8.14: Employed new registrants in Australia where initial qualification in Australia, by State, Selected statistics, Registered nurses, Western Australia, 2014-17

Western Australia				
	2014	2015	2016	2017
Number Employed	553	602	678	695
Average weekly hours worked	36.4	37.2	36.3	35.2
FTE	529.9	589.9	648.2	643.4
FTE rate	21.0	23.2	25.3	24.9
Number with public sector hours	374	380	390	455
Number with private sector hours	188	237	298	258
Part time (percent)	49.2	50.5	53.4	55.0
Women (percent)	91.9	90.7	93.7	92.4
Indigenous (percent)	0.4	1.5	1.5	2.0
Age Group				
Aged <25 (number)	284	318	345	361
Aged 25–34 (number)	153	170	209	194
Aged 35–44 (number)	82	80	89	89
Aged 45–54 (number)	28	31	32	44
Aged 55+ (number)	6	np	np	7
Remoteness area				
Number in Major cities	490	521	587	585
Number in Inner regional areas	26	37	37	35
Number in Outer regional areas	23	23	28	42
Number in Remote/Very remote areas	14	21	26	33
Number in unknown/overseas areas	0	0	0	0

Source: NHWDS Nursing and Midwifery Practitioners, 2013-2017

For further information on these tables, refer to the 'Notes' sheet

Table 8.15: Employed new registrants in Australia where initial qualification in Australia, by State, Selected statistics, Registered nurses, South Australia, 2014-17

South Australia				
	2014	2015	2016	2017
Number Employed	486	472	448	464
Average weekly hours worked	33.9	33.8	34.3	33.0
FTE	433.7	420.4	404.6	403.4
FTE rate	25.7	24.7	23.6	23.4
Number with public sector hours	329	312	322	298
Number with private sector hours	167	176	133	176
Part time (percent)	53.1	55.1	54.0	61.6
Women (percent)	89.7	87.3	87.7	87.1
Indigenous (percent)	0.6	0.9	1.6	1.1
Age Group				
Aged <25 (number)	258	236	241	241
Aged 25–34 (number)	139	154	124	153
Aged 35–44 (number)	60	61	59	40
Aged 45–54 (number)	28	16	18	27
Aged 55+ (number)	np	5	6	np
Remoteness area				
Number in Major cities	423	401	365	392
Number in Inner regional areas	10	12	17	14
Number in Outer regional areas	45	49	57	53
Number in Remote/Very remote areas	8	10	9	5
Number in unknown/overseas areas	0	0	0	0

Source: NHWDS Nursing and Midwifery Practitioners, 2013-2017

For further information on these tables, refer to the 'Notes' sheet

Table 8.16: Employed new registrants in Australia where initial qualification in Australia, by State, Selected statistics, Registered nurses, Tasmania, 2014-17

Tasmania				
	2014	**2015**	**2016**	**2017**
Number Employed	154	182	213	230
Average weekly hours worked	34.2	34.0	33.3	34.4
FTE	138.7	162.6	186.8	208.5
FTE rate	27.0	31.5	36.1	40.0
Number with public sector hours	97	125	153	163
Number with private sector hours	62	60	67	71
Part time (percent)	73.4	74.2	77.9	71.3
Women (percent)	82.5	93.4	87.3	89.6
Indigenous (percent)	2.6	2.2	1.9	2.7
Age Group				
Aged <25 (number)	85	98	106	111
Aged 25–34 (number)	42	48	55	62
Aged 35–44 (number)	17	27	31	36
Aged 45–54 (number)	10	8	19	18
Aged 55+ (number)	0	np	np	np
Remoteness area				
Number in Major cities	0	0	0	0
Number in Inner regional areas	133	147	173	185
Number in Outer regional areas	21	34	37	42
Number in Remote/Very remote areas	0	np	np	np
Number in unknown/overseas areas	0	0	0	0

Source: NHWDS Nursing and Midwifery Practitioners, 2013-2017

For further information on these tables, refer to the 'Notes' sheet

Table 8.17: Employed new registrants in Australia where initial qualification in Australia, by State, Selected statistics, Registered nurses, Australian Capital Territory, 2014-17

Australian Capital Territory				
	2014	**2015**	**2016**	**2017**
Number Employed	97	100	152	142
Average weekly hours worked	38.9	37.4	38.8	37.0
FTE	99.2	98.5	155.2	138.4
FTE rate	25.5	24.8	38.5	33.7
Number with public sector hours	83	76	101	103
Number with private sector hours	16	28	53	41
Part time (percent)	21.6	26.0	25.7	26.1
Women (percent)	90.7	85.0	86.2	81.7
Indigenous (percent)	1.0	0.0	1.3	1.4
Age Group				
Aged <25 (number)	50	52	77	72
Aged 25–34 (number)	30	36	54	49
Aged 35–44 (number)	11	9	13	16
Aged 45–54 (number)	5	np	5	np
Aged 55+ (number)	np	np	np	np
Remoteness area				
Number in Major cities	97	100	152	142
Number in Inner regional areas	0	0	0	0
Number in Outer regional areas	0	0	0	0
Number in Remote/Very remote areas	0	0	0	0
Number in unknown/overseas areas	0	0	0	0

Source: NHWDS Nursing and Midwifery Practitioners, 2013-2017
For further information on these tables, refer to the 'Notes' sheet

Table 8.18: Employed new registrants in Australia where initial qualification in Australia, by State, Selected statistics, Registered nurses, Northern Territory, 2014-17

Northern Territory				
	2014	2015	2016	2017
Number Employed	74	74	79	75
Average weekly hours worked	36.3	36.3	35.7	36.3
FTE	70.6	70.7	74.2	71.7
FTE rate	29.0	28.9	30.2	29.1
Number with public sector hours	69	61	61	63
Number with private sector hours	5	14	19	12
Part time (percent)	50.0	47.3	53.2	41.3
Women (percent)	87.8	89.2	83.5	89.3
Indigenous (percent)	5.5	8.2	5.2	5.3
Age Group				
Aged <25 (number)	30	35	34	28
Aged 25–34 (number)	28	28	33	35
Aged 35–44 (number)	7	6	9	11
Aged 45–54 (number)	5	4	np	np
Aged 55+ (number)	4	np	0	0
Remoteness area				
Number in Major cities	0	0	0	0
Number in Inner regional areas	0	0	0	0
Number in Outer regional areas	44	44	47	44
Number in Remote/Very remote areas	30	30	32	31
Number in unknown/overseas areas	0	0	0	0

Source: NHWDS Nursing and Midwifery Practitioners, 2013-2017
For further information on these tables, refer to the 'Notes' sheet

Employed new registrants - Enrolled Nurses

Table 8.19: Employed new registrants in Australia where initial qualification in Australia, Selected statistics, Enrolled nurses, Australia, 2014-17

Australia				
	2014	**2015**	**2016**	**2017**
Number Employed	2,618	2,380	2,684	2,700
Average weekly hours worked	30.6	30.4	30.2	29.9
FTE	2,110.3	1,904.1	2,133.7	2,125.0
FTE rate	71.3	63.7	74.9	72.6
Number with public sector hours	1,111	1,074	1,136	1,202
Number with private sector hours	1,640	1,408	1,648	1,619
Part time (percent)	70.8	70.7	71.4	74.0
Women (percent)	89.3	88.0	88.2	88.0
Indigenous (percent)	2.8	2.6	3.5	3.1
Age Group				
Aged <25 (number)	731	723	843	766
Aged 25–34 (number)	722	723	810	882
Aged 35–44 (number)	609	476	580	569
Aged 45–54 (number)	433	364	361	403
Aged 55+ (number)	123	94	90	80
Remoteness area				
Number in Major cities	1,731	1,644	1,791	1,776
Number in Inner regional areas	602	485	583	588
Number in Outer regional areas	256	218	279	290
Number in Remote/Very remote areas	29	33	31	46
Number in unknown/overseas areas	0	0	0	0

Source: NHWDS Nursing and Midwifery Practitioners, 2013-2017

For further information on these tables, refer to the 'Notes' sheet

Table 8.20: Employed new registrants in Australia where initial qualification in Australia, by State, Selected statistics, Enrolled nurses, New South Wales, 2014-17

New South Wales				
	2014	2015	2016	2017
Number Employed	517	499	540	575
Average weekly hours worked	33.4	33.7	33.0	32.9
FTE	454.5	442.8	468.5	497.1
FTE rate	6.0	5.8	6.1	6.3
Number with public sector hours	262	289	290	327
Number with private sector hours	282	231	268	268
Part time (percent)	57.1	51.1	54.3	54.8
Women (percent)	88.6	84.8	87.0	87.3
Indigenous (percent)	5.3	5.6	6.0	5.4
Age Group				
Aged <25 (number)	138	160	164	155
Aged 25–34 (number)	149	134	166	192
Aged 35–44 (number)	114	96	117	111
Aged 45–54 (number)	96	95	77	102
Aged 55+ (number)	20	14	16	15
Remoteness area				
Number in Major cities	310	320	343	357
Number in Inner regional areas	164	132	158	157
Number in Outer regional areas	41	43	36	54
Number in Remote/Very remote areas	np	4	np	7
Number in unknown/overseas areas	0	0	0	0

Source: NHWDS Nursing and Midwifery Practitioners, 2013-2017

For further information on these tables, refer to the 'Notes' sheet

Table 8.21: Employed new registrants in Australia where initial qualification in Australia, by State, Selected statistics, Enrolled nurses, Victoria, 2014-17

Victoria				
	2014	2015	2016	2017
Number Employed	816	696	845	901
Average weekly hours worked	28.7	27.3	27.5	27.7
FTE	616.1	499.9	610.9	657.8
FTE rate	10.4	8.3	9.9	10.4
Number with public sector hours	335	304	335	376
Number with private sector hours	537	421	549	578
Part time (percent)	78.9	82.5	81.5	82.0
Women (percent)	91.4	87.6	86.7	87.8
Indigenous (percent)	0.5	0.6	1.1	1.7
Age Group				
Aged <25 (number)	264	222	302	296
Aged 25–34 (number)	204	219	268	292
Aged 35–44 (number)	191	132	167	181
Aged 45–54 (number)	120	91	88	111
Aged 55+ (number)	37	32	20	21
Remoteness area				
Number in Major cities	537	466	574	597
Number in Inner regional areas	228	193	223	236
Number in Outer regional areas	50	37	48	67
Number in Remote/Very remote areas	np	0	0	np
Number in unknown/overseas areas	0	0	0	0

Source: NHWDS Nursing and Midwifery Practitioners, 2013-2017

For further information on these tables, refer to the 'Notes' sheet

Table 8.22: Employed new registrants in Australia where initial qualification in Australia, by State, Selected statistics, Enrolled nurses, Queensland, 2014-17

Queensland				
	2014	2015	2016	2017
Number Employed	590	594	685	612
Average weekly hours worked	30.6	30.7	30.8	30.6
FTE	475.1	480.2	554.6	493.0
FTE rate	10.1	10.0	11.4	10.0
Number with public sector hours	241	247	248	213
Number with private sector hours	372	371	462	421
Part time (percent)	73.1	72.4	73.7	77.6
Women (percent)	88.3	88.2	90.2	87.4
Indigenous (percent)	3.5	1.2	4.8	3.2
Age Group				
Aged <25 (number)	162	161	195	163
Aged 25–34 (number)	161	187	186	209
Aged 35–44 (number)	145	125	154	128
Aged 45–54 (number)	88	96	114	91
Aged 55+ (number)	34	25	36	21
Remoteness area				
Number in Major cities	418	429	457	431
Number in Inner regional areas	93	82	111	97
Number in Outer regional areas	70	75	109	75
Number in Remote/Very remote areas	9	8	8	9
Number in unknown/overseas areas	0	0	0	0

Source: NHWDS Nursing and Midwifery Practitioners, 2013-2017

For further information on these tables, refer to the 'Notes' sheet

Table 8.23: Employed new registrants in Australia where initial qualification in Australia, by State, Selected statistics, Enrolled nurses, Western Australia, 2014-17

Western Australia				
	2014	**2015**	**2016**	**2017**
Number Employed	299	263	220	234
Average weekly hours worked	33.9	33.6	33.2	31.6
FTE	266.7	232.4	192.2	194.9
FTE rate	10.6	9.1	7.5	7.6
Number with public sector hours	127	93	91	110
Number with private sector hours	181	174	133	132
Part time (percent)	58.2	69.2	70.0	75.2
Women (percent)	91.6	95.1	92.7	92.7
Indigenous (percent)	4.1	3.0	4.6	2.6
Age Group				
Aged <25 (number)	98	103	89	67
Aged 25–34 (number)	80	72	53	61
Aged 35–44 (number)	51	52	49	57
Aged 45–54 (number)	53	29	23	37
Aged 55+ (number)	17	7	6	12
Remoteness area				
Number in Major cities	232	223	182	164
Number in Inner regional areas	27	13	9	28
Number in Outer regional areas	31	19	25	28
12	9	8	4	14
Number in unknown/overseas areas	0	0	0	0

Source: NHWDS Nursing and Midwifery Practitioners, 2013-2017

For further information on these tables, refer to the 'Notes' sheet

Table 8.24: Employed new registrants in Australia where initial qualification in Australia, by State, Selected statistics, Enrolled nurses, South Australia, 2014-17

South Australia				
	2014	**2015**	**2016**	**2017**
Number Employed	279	231	263	233
Average weekly hours worked	27.8	26.7	27.7	25.9
FTE	204.1	162.1	191.5	158.7
FTE rate	12.1	9.5	11.2	9.2
Number with public sector hours	110	97	95	99
Number with private sector hours	183	151	178	143
Part time (percent)	81.4	81.4	78.3	86.3
Women (percent)	84.6	87.9	87.1	85.4
Indigenous (percent)	1.4	3.5	3.1	0.9
Age Group				
Aged <25 (number)	48	51	60	54
Aged 25–34 (number)	97	86	100	84
Aged 35–44 (number)	75	53	66	61
Aged 45–54 (number)	47	31	34	27
Aged 55+ (number)	12	10	np	7
Remoteness area				
Number in Major cities	207	178	192	176
Number in Inner regional areas	22	20	28	16
Number in Outer regional areas	43	26	36	33
Number in Remote/Very remote areas	7	7	7	8
Number in unknown/overseas areas	0	0	0	0

Source: NHWDS Nursing and Midwifery Practitioners, 2013-2017

For further information on these tables, refer to the 'Notes' sheet

Table 8.25: Employed new registrants in Australia where initial qualification in Australia, by State, Selected statistics, Enrolled nurses, Tasmania, 2014-17

Tasmania				
	2014	2015	2016	2017
Number Employed	80	57	67	78
Average weekly hours worked	28.0	31.2	32.1	30.5
FTE	58.8	46.7	56.6	62.7
FTE rate	11.5	9.1	10.9	12.0
Number with public sector hours	25	22	35	39
Number with private sector hours	59	41	34	46
Part time (percent)	83.8	75.4	67.2	75.6
Women (percent)	90.0	89.5	89.6	92.3
Indigenous (percent)	6.3	8.8	1.5	6.4
Age Group				
Aged <25 (number)	11	12	12	6
Aged 25–34 (number)	19	12	17	22
Aged 35–44 (number)	24	11	15	18
Aged 45–54 (number)	24	17	16	30
Aged 55+ (number)	np	5	7	np
Remoteness area				
Number in Major cities	0	0	0	0
Number in Inner regional areas	68	45	54	54
Number in Outer regional areas	12	11	12	22
Number in Remote/Very remote areas	0	np	np	np
Number in unknown/overseas areas	0	0	0	0

Source: NHWDS Nursing and Midwifery Practitioners, 2013-2017

For further information on these tables, refer to the 'Notes' sheet

Table 8.26: Employed new registrants in Australia where initial qualification in Australia, by State, Selected statistics, Enrolled nurses, Australian Capital Territory, 2014-17

Australian Capital Territory				
	2014	2015	2016	2017
Number Employed	27	28	43	51
Average weekly hours worked	34.0	39.1	35.2	34.7
FTE	24.2	28.8	39.8	46.6
FTE rate	6.2	7.3	9.9	11.3
Number with public sector hours	11	18	29	31
Number with private sector hours	16	10	14	21
Part time (percent)	44.4	21.4	41.9	41.2
Women (percent)	85.2	82.1	76.7	86.3
Indigenous (percent)	0.0	3.6	2.4	6.0
Age Group				
Aged <25 (number)	8	10	14	21
Aged 25–34 (number)	6	7	15	15
Aged 35–44 (number)	8	6	10	10
Aged 45–54 (number)	4	4	4	4
Aged 55+ (number)	np	np	0	np
Remoteness area				
Number in Major cities	27	28	43	51
Number in Inner regional areas	0	0	0	0
Number in Outer regional areas	0	0	0	0
Number in Remote/Very remote areas	0	0	0	0
Number in unknown/overseas areas	0	0	0	0

Source: NHWDS Nursing and Midwifery Practitioners, 2013-2017

For further information on these tables, refer to the 'Notes' sheet

Table 8.27: Employed new registrants in Australia where initial qualification in Australia, by State, Selected statistics, Enrolled nurses, Northern Territory, 2014-17

Northern Territory				
	2014	2015	2016	2017
Number Employed	10	12	21	16
Average weekly hours worked	41.1	35.6	35.5	33.7
FTE	10.8	11.2	19.6	14.2
FTE rate	4.4	4.6	8.0	5.8
Number with public sector hours	0	4	13	7
Number with private sector hours	10	9	10	10
Part time (percent)	40.0	41.7	28.6	68.8
Women (percent)	90.0	83.3	90.5	93.8
Indigenous (percent)	0.0	0.0	0.0	6.3
Age Group				
Aged <25 (number)	np	4	7	4
Aged 25–34 (number)	6	6	5	7
Aged 35–44 (number)	np	np	np	np
Aged 45–54 (number)	np	np	5	np
Aged 55+ (number)	0	0	np	np
Remoteness area				
Number in Major cities	0	0	0	0
Number in Inner regional areas	0	0	0	0
Number in Outer regional areas	9	7	13	11
Number in Remote/Very remote areas	np	5	8	5
Number in unknown/overseas areas	0	0	0	0

Source: NHWDS Nursing and Midwifery Practitioners, 2013-2017

For further information on these tables, refer to the 'Notes' sheet

Employed new registrants - Registered Midwives

Table 8.28: Employed new registrants in Australia where initial qualification in Australia, Selected statistics, registered midwives with midwifery hours, Australia, 2014-17

Australia				
	2014	**2015**	**2016**	**2017**
Number Employed	451	468	490	591
Average weekly midwifery hours worked	31.2	29.7	30.9	28.5
FTE in midwifery	370.8	366.3	398.6	443.3
FTE in midwifery rate	13.4	15.2	16.3	15.0
Number with public sector midwifery hours	400	420	449	537
Number with private sector midwifery hours	61	56	46	63
Part time (percent)	60.1	61.8	61.2	66.5
Women (percent)	99.8	98.9	99.8	99.3
Indigenous (percent)	2.0	2.2	2.5	1.5
Age Group				
Aged <25 (number)	208	225	211	298
Aged 25–34 (number)	135	121	148	163
Aged 35–44 (number)	74	94	100	92
Aged 45–54 (number)	30	19	27	34
Aged 55+ (number)	4	9	4	4
Remoteness area				
Number in Major cities	369	354	394	473
Number in Inner regional areas	40	69	64	67
Number in Outer regional areas	34	41	27	44
Number in Remote/Very remote areas	8	4	5	7
Number in unknown/overseas areas	0	0	0	0

Source: NHWDS Nursing and Midwifery Practitioners, 2013-2017

For further information on these tables, refer to the 'Notes' sheet

Table 8.29: Employed new registrants in Australia where initial qualification in Australia, by State, Selected statistics, registered midwives with midwifery hours, New South Wales, 2014-17

New South Wales				
	2014	2015	2016	2017
Number Employed	106	85	99	139
Average weekly midwifery hours worked	37.0	36.8	37.0	36.3
FTE in midwifery	103.1	82.3	96.3	132.9
FTE in midwifery rate	1.4	1.1	1.2	1.7
Number with public sector midwifery hours	100	78	94	133
Number with private sector midwifery hours	6	8	5	7
Part time (percent)	29.2	23.5	29.3	30.9
Women (percent)	100.0	97.6	100.0	99.3
Indigenous (percent)	1.9	1.2	4.1	0.7
Age Group				
Aged <25 (number)	40	30	33	56
Aged 25–34 (number)	36	29	32	50
Aged 35–44 (number)	17	22	23	23
Aged 45–54 (number)	11	np	10	9
Aged 55+ (number)	np	np	np	np
Remoteness area				
Number in Major cities	90	64	72	113
Number in Inner regional areas	13	18	24	22
Number in Outer regional areas	np	np	np	4
Number in Remote/Very remote areas	0	0	0	0
Number in unknown/overseas areas	0	0	0	0

Source: NHWDS Nursing and Midwifery Practitioners, 2013-2017

For further information on these tables, refer to the 'Notes' sheet

Table 8.30: Employed new registrants in Australia where initial qualification in Australia, by State, Selected statistics, registered midwives with midwifery hours, Victoria, 2014-17

Victoria				
	2014	2015	2016	2017
Number Employed	146	153	165	192
Average weekly midwifery hours worked	29.2	25.2	27.1	25.3
FTE in midwifery	112.3	101.3	117.5	127.7
FTE in midwifery rate	1.9	1.7	1.9	2.0
Number with public sector midwifery hours	128	136	152	175
Number with private sector midwifery hours	22	20	15	18
Part time (percent)	69.2	75.8	70.9	82.3
Women (percent)	99.3	99.3	99.4	98.4
Indigenous (percent)	0.0	2.7	1.2	1.0
Age Group				
Aged <25 (number)	83	89	91	123
Aged 25–34 (number)	39	30	42	41
Aged 35–44 (number)	22	27	30	22
Aged 45–54 (number)	np	np	np	6
Aged 55+ (number)	0	4	0	0
Remoteness area				
Number in Major cities	129	124	139	169
Number in Inner regional areas	17	27	24	21
Number in Outer regional areas	0	np	np	np
Number in Remote/Very remote areas	0	0	0	0
Number in unknown/overseas areas	0	0	0	0

Source: NHWDS Nursing and Midwifery Practitioners, 2013-2017

For further information on these tables, refer to the 'Notes' sheet

Table 8.31: Employed new registrants in Australia where initial qualification in Australia, by State, Selected statistics, registered midwives with midwifery hours, Queensland, 2014-17

Queensland				
	2014	2015	2016	2017
Number Employed	107	136	130	155
Average weekly midwifery hours worked	26.3	27.0	29.1	23.2
FTE in midwifery	74.1	96.7	99.5	94.6
FTE in midwifery rate	1.6	2.0	2.1	1.9
Number with public sector midwifery hours	89	122	124	134
Number with private sector midwifery hours	20	18	9	28
Part time (percent)	72.0	68.4	70.0	78.1
Women (percent)	100	99.3	100	100
Indigenous (percent)	2.8	0.7	2.3	2.0
Age Group				
Aged <25 (number)	48	66	51	84
Aged 25–34 (number)	29	40	44	33
Aged 35–44 (number)	19	25	28	28
Aged 45–54 (number)	11	4	5	9
Aged 55+ (number)	0	np	np	np
Remoteness area				
Number in Major cities	71	93	105	109
Number in Inner regional areas	8	19	13	17
Number in Outer regional areas	24	22	10	25
Number in Remote/Very remote areas	4	np	np	4
Number in unknown/overseas areas	0	0	0	0

Source: NHWDS Nursing and Midwifery Practitioners, 2013-2017

For further information on these tables, refer to the 'Notes' sheet

Table 8.32: Employed new registrants in Australia where initial qualification in Australia, by State, Selected statistics, registered midwives with midwifery hours, Western Australia, 2014-17

Western Australia				
	2014	2015	2016	2017
Number Employed	22	24	31	33
Average weekly midwifery hours worked	35.1	36.6	31.9	28.8
FTE in midwifery	20.3	23.1	26.1	25.1
FTE in midwifery rate	0.8	0.9	1.0	1.0
Number with public sector midwifery hours	18	21	17	28
Number with private sector midwifery hours	5	np	14	5
Part time (percent)	45.5	54.2	67.7	69.7
Women (percent)	100	100	100	100
Indigenous (percent)	0.0	4.2	3.2	3.0
Age Group				
Aged <25 (number)	11	10	11	13
Aged 25–34 (number)	6	7	10	9
Aged 35–44 (number)	np	4	7	7
Aged 45–54 (number)	np	np	np	4
Aged 55+ (number)	0	np	0	0
Remoteness area				
Number in Major cities	21	22	28	31
Number in Inner regional areas	np	np	0	np
Number in Outer regional areas	0	0	np	np
Number in Remote/Very remote areas	0	0	0	0
Number in unknown/overseas areas	0	0	0	0

Source: NHWDS Nursing and Midwifery Practitioners, 2013-2017

For further information on these tables, refer to the 'Notes' sheet

Table 8.33: Employed new registrants in Australia where initial qualification in Australia, by State, Selected statistics, registered midwives with midwifery hours, South Australia, 2014-17

South Australia				
	2014	2015	2016	2017
Number Employed	48	41	35	48
Average weekly midwifery hours worked	34.1	34.7	35.7	33.8
FTE in midwifery	43.1	37.5	32.9	42.7
FTE in midwifery rate	2.6	2.2	1.9	2.5
Number with public sector midwifery hours	43	37	33	43
Number with private sector midwifery hours	6	4	np	5
Part time (percent)	75.0	70.7	57.1	77.1
Women (percent)	100	100	100	100
Indigenous (percent)	2.1	4.9	2.9	4.3
Age Group				
Aged <25 (number)	21	23	20	20
Aged 25–34 (number)	14	9	6	14
Aged 35–44 (number)	7	6	6	10
Aged 45–54 (number)	4	np	np	np
Aged 55+ (number)	np	0	0	np
Remoteness area				
Number in Major cities	43	35	32	39
Number in Inner regional areas	0	np	np	np
Number in Outer regional areas	4	np	np	5
Number in Remote/Very remote areas	np	np	0	np
Number in unknown/overseas areas	0	0	0	0

Source: NHWDS Nursing and Midwifery Practitioners, 2013-2017

For further information on these tables, refer to the 'Notes' sheet

Table 8.34: Employed new registrants in Australia where initial qualification in Australia, by State, Selected statistics, registered midwives with midwifery hours, Tasmania, 2014-17

Tasmania				
	2014	**2015**	**2016**	**2017**
Number Employed	np	5	np	np
Average weekly midwifery hours worked	60.0	36.4	32.0	24.7
FTE in midwifery	np	4.8	np	np
FTE in midwifery rate	0.3	0.9	0.2	0.4
Number with public sector midwifery hours	np	np	np	np
Number with private sector midwifery hours	np	np	0	0
Part time (percent)	0.0	60.0	100	100
Women (percent)	100	100	100	100
Indigenous (percent)	0	0	0	0
Age Group				
Aged <25 (number)	np	np	0	0
Aged 25–34 (number)	0	np	np	np
Aged 35–44 (number)	0	np	0	0
Aged 45–54 (number)	0	np	0	np
Aged 55+ (number)	0	0	0	0
Remoteness area				
Number in Major cities	0	0	0	0
Number in Inner regional areas	np	np	np	np
Number in Outer regional areas	0	4	0	0
Number in Remote/Very remote areas	0	0	0	0
Number in unknown/overseas areas	0	0	0	0

Source: NHWDS Nursing and Midwifery Practitioners, 2013-2017

For further information on these tables, refer to the 'Notes' sheet

Table 8.35: Employed new registrants in Australia where initial qualification in Australia, by State, Selected statistics, registered midwives with midwifery hours, Australian Capital Territory, 2014-17

Australian Capital Territory				
	2014	2015	2016	2017
Number Employed	15	16	18	12
Average weekly midwifery hours worked	28.6	31.0	31.6	38.2
FTE in midwifery	11.3	13.1	14.9	12.1
FTE in midwifery rate	2.9	3.3	3.7	2.9
Number with public sector midwifery hours	15	16	18	12
Number with private sector midwifery hours	np	0	0	0
Part time (percent)	86.7	68.8	83.3	16.7
Women (percent)	100	93.8	100	100
Indigenous (percent)	6.7	6.3	5.6	0.0
Age Group				
Aged <25 (number)	4	4	np	np
Aged 25–34 (number)	6	np	8	7
Aged 35–44 (number)	5	5	np	np
Aged 45–54 (number)	0	np	4	np
Aged 55+ (number)	0	np	np	0
Remoteness area				
Number in Major cities	15	16	18	12
Number in Inner regional areas	0	0	0	0
Number in Outer regional areas	0	0	0	0
Number in Remote/Very remote areas	0	0	0	0
Number in unknown/overseas areas	0	0	0	0

Source: NHWDS Nursing and Midwifery Practitioners, 2013-2017

For further information on these tables, refer to the 'Notes' sheet

Table 8.36: Employed new registrants in Australia where initial qualification in Australia, by State, Selected statistics, registered midwives with midwifery hours, Northern Territory, 2014-17

Northern Territory				
	2014	2015	2016	2017
Number Employed	6	8	11	9
Average weekly midwifery hours worked	31.3	36.0	36.4	27.2
FTE in midwifery	4.9	7.6	10.5	6.4
FTE in midwifery rate	2.0	3.1	4.3	2.6
Number with public sector midwifery hours	6	7	10	9
Number with private sector midwifery hours	0	np	np	0
Part time (percent)	50.0	50.0	54.5	66.7
Women (percent)	100	100	100	100
Indigenous (percent)	33.3	0.0	0.0	0.0
Age Group				
Aged <25 (number)	0	np	np	np
Aged 25–34 (number)	5	np	5	7
Aged 35–44 (number)	np	4	np	0
Aged 45–54 (number)	0	np	0	0
Aged 55+ (number)	0	0	0	np
Remoteness area				
Number in Major cities	0	0	0	0
Number in Inner regional areas	0	0	0	0
Number in Outer regional areas	np	7	8	7
Number in Remote/Very remote areas	np	np	np	np
Number in unknown/overseas areas	0	0	0	0

Source: NHWDS Nursing and Midwifery Practitioners, 2013-2017

For further information on these tables, refer to the 'Notes' sheet

PART 9 - COMPARISON BETWEEN EMPLOYED NEW REGISTRANTS WHERE INITIAL QUALIFICATION IN AUSTRALIA AND ALL EMPLOYED NEW REGISTRANTS

All Nurses and Midwives

Table 9.1: Employed new registrants in Australia where initial qualification in Australia, Selected statistics. All Nurses and Midwives, Australia, 2014-17

Australia				
	2014	2015	2016	2017
Number Employed	9,517	9,336	10,848	11,017
Average weekly hours worked	34.2	34.3	34.3	33.7
FTE	8,554.2	8,428.2	9,796.3	9,782.7
FTE rate	290.0	289.3	336.2	327.9
Number with public sector hours	5,929	5,945	6,884	7,049
Number with private sector hours	3,859	3,634	4,215	4,226
Part time (percent)	54.1	54.9	54.5	58.9
Women (percent)	89.5	89.1	88.1	88.4
Indigenous (percent)	1.7	1.9	2.0	2.3
Age Group				
Aged <25 (number)	4,210	4,211	4,780	4,970
Aged 25–34 (number)	2,829	2,926	3,514	3,575
Aged 35–44 (number)	1,488	1,347	1,604	1,539
Aged 45–54 (number)	801	689	780	771
Aged 55+ (number)	189	163	170	162
Remoteness area				
Number in Major cities	6,977	6,888	7,961	7,928
Number in Inner regional areas	1,675	1,583	1,853	1,955
Number in Outer regional areas	736	719	863	926
Number in Remote/ Very remote areas	129	146	171	208
Number in unknown/overseas areas	0	0	0	0

Table 9.2: Employed new registrants in Australia, Selected statistics, All nurses and Midwives, Australia, 2014-17

Australia			
2014	2015	2016	2017
13,880	13,915	15,607	16,138
33.9	34.0	34.1	33.7
12,399.9	12,450.8	13,990.2	14,296.7
441.4	431.8	480.1	492.7
8,449	8,545	9,450	9,857
5,983	5,858	6,695	6,864
54.1	55.0	54.9	58.0
88.4	88.8	87.5	87.6
1.5	1.7	1.8	2.0
5,078	5,420	5,744	6,012
4,870	4,987	6,076	6,433
2,317	2,121	2,329	2,327
1,279	1,107	1,150	1,104
336	280	308	262
10,368	10,505	11,802	12,017
2,293	2,166	2,417	2,576
1,004	1,038	1,150	1,246
215	206	238	299
0	0	0	0

Source: NHWDS Nursing and Midwifery Practitioners, 2013-2017
For further information on these tables, refer to the 'Notes' sheet

Registered Nurses

Table 9.3: Employed new registrants in Australia where initial qualification in Australia, Selected statistics, Registered nurses, Australia, 2014-17

Australia				
	2014	2015	2016	2017
Number Employed	6,590	6,664	7,832	7,966
Average weekly hours worked	35.6	35.7	35.7	35.0
FTE	6,167.2	6,266.6	7,367.2	7,341.3
FTE rate	208.4	213.5	248.3	243.1
Number with public sector hours	4,540	4,599	5,436	5,513
Number with private sector hours	2,186	2,206	2,546	2,586
Part time (percent)	47.1	49.0	48.4	53.7
Women (percent)	89.0	89.0	87.5	88.0
Indigenous (percent)	1.3	1.6	1.4	2.0
Age Group				
Aged <25 (number)	3,376	3,387	3,836	4,080
Aged 25–34 (number)	1,992	2,122	2,583	2,571
Aged 35–44 (number)	818	783	941	897
Aged 45–54 (number)	341	311	394	340
Aged 55+ (number)	63	61	78	78
Remoteness area				
Number in Major cities	4,975	5,019	5,903	5,866
Number in Inner regional areas	1,055	1,058	1,232	1,328
Number in Outer regional areas	465	477	560	616
Number in Remote/ Very remote areas	95	110	137	156
Number in unknown/overseas areas	0	0	0	0

Table 9.4: Employed new registrants in Australia, Selected statistics, Registered nurses, Australia, 2014-17

Australia			
2014	2015	2016	2017
9,616	9,871	11,153	11,777
35.1	35.2	35.3	34.8
8,880.5	9,137.9	10,373.7	10,774.4
322.1	320.3	359.5	371.8
6,371	6,539	7,272	7,680
3,570	3,660	4,251	4,503
47.8	49.6	49.3	53.1
87.8	88.5	86.8	87.0
1.1	1.5	1.3	1.7
3,922	4,176	4,381	4,699
3,637	3,777	4,649	5,031
1,349	1,268	1,397	1,409
577	527	571	501
131	123	155	137
7,443	7,658	8,706	9,018
1,379	1,374	1,522	1,697
627	679	738	827
167	160	187	235
0	0	0	0

Source: NHWDS Nursing and Midwifery Practitioners, 2013-2017
For further information on these tables, refer to the 'Notes' sheet

Enrolled Nurses

Table 9.5: Employed new registrants in Australia where initial qualification in Australia, Selected statistics, Enrolled nurses, Australia, 2014-17

Australia				
	2014	2015	2016	2017
Number Employed	2,618	2,380	2,684	2,700
Average weekly hours worked	30.6	30.4	30.2	29.9
FTE	2,110.3	1,904.1	2,133.7	2,125.0
FTE rate	71.3	63.7	74.9	72.6
Number with public sector hours	1,111	1,074	1,136	1,202
Number with private sector hours	1,640	1,408	1,648	1,619
Part time (percent)	70.8	70.7	71.4	74.0
Women (percent)	89.3	88.0	88.2	88.0
Indigenous (percent)	2.8	2.6	3.5	3.1
Age Group				
Aged <25 (number)	731	723	843	766
Aged 25–34 (number)	722	723	810	882
Aged 35–44 (number)	609	476	580	569
Aged 45–54 (number)	433	364	361	403
Aged 55+ (number)	123	94	90	80
Remoteness area				
Number in Major cities	1,731	1,644	1,791	1,776
Number in Inner regional areas	602	485	583	588
Number in Outer regional areas	256	218	279	290
Number in Remote/ Very remote areas	29	33	31	46
Number in unknown/overseas areas	0	0	0	0

Table 9.6: Employed new registrants in Australia, Selected statistics, Enrolled nurses, Australia, 2014-17

Australia			
2014	2015	2016	2017
3,833	3,650	4,033	3,909
31.0	30.9	30.6	30.3
3,131.6	2,964.9	3,242.7	3,113.0
104.0	95.1	103.4	104.5
1,709	1,657	1,797	1,762
2,340	2,148	2,401	2,315
69.6	68.9	70.0	72.8
88.6	88.4	88.0	87.8
2.8	2.5	3.5	3.0
1,041	1,117	1,247	1,170
1,065	1,088	1,258	1,234
871	744	834	822
660	553	546	566
196	148	148	117
2,552	2,535	2,756	2,638
886	743	851	828
355	331	383	388
40	41	43	55
0	0	0	0

Source: NHWDS Nursing and Midwifery Practitioners, 2013-2017
For further information on these tables, refer to the 'Notes' sheet

Midwives

Table 9.7: Employed new registrants in Australia where initial qualification in Australia, Selected statistics, Registered midwives with midwifery hours, Australia, 2014-17

Australia				
	2014	2015	2016	2017
Number Employed	451	468	490	591
Average weekly hours worked	31.2	29.7	30.9	28.5
FTE	370.8	366.3	398.6	443.3
FTE rate	13.4	15.2	16.3	15.0
Number with public sector hours	400	420	449	537
Number with private sector hours	61	56	46	63
Part time (percent)	60.1	61.8	61.2	66.5
Women (percent)	99.8	98.9	99.8	99.3
Indigenous (percent)	2.0	2.2	2.5	1.5
Age Group				
Aged <25 (number)	208	225	211	298
Aged 25–34 (number)	135	121	148	163
Aged 35–44 (number)	74	94	100	92
Aged 45–54 (number)	30	19	27	34
Aged 55+ (number)	4	9	4	4
Remoteness area				
Number in Major cities	369	354	394	473
Number in Inner regional areas	40	69	64	67
Number in Outer regional areas	34	41	27	44
Number in Remote/ Very remote areas	8	4	5	7
Number in unknown/overseas areas	0	0	0	0

Table 9.8: Employed new registrants in Australia, Selected statistics, registered midwives with midwifery hours, Australia, 2014-17

Australia			
2014	2015	2016	2017
605	617	616	726
31.8	30.0	31.0	29.3
506.7	487.0	500.9	559.6
19.3	21.1	21.8	19.9
509	530	544	639
119	103	82	102
55.4	60.0	60.2	62.8
99.5	99.0	99.8	99.4
1.6	2.0	2.2	1.5
224	274	233	334
203	174	209	216
120	119	129	119
47	39	38	48
11	11	7	9
494	474	499	575
57	84	75	84
42	51	32	57
12	8	10	10
0	0	0	0

Source: NHWDS Nursing and Midwifery Practitioners, 2013-2017
For further information on these tables, refer to the 'Notes' sheet

PART 10 - EMPLOYED NEW REGISTRANTS BY INDIGENOUS STATUS, AREA OF NURSING, SETTING OF MAIN JOB AND VISA TYPE

Table 10.1: First year of registration for employed nurses and midwives by indigenous status, area of nursing, setting of main job and visa type, 2014-17

Indigenous status	2014	2015	2016	2017
Indigenous	170	182	217	258
Non-Indigenous	10,911	10,227	12,062	12,619
Not stated	2,799	3,506	3,328	3,261
Total	**13,880**	**13,915**	**15,607**	**16,138**
Area of Nursing				
Aged care	3,137	2,853	3,400	3,412
Antenatal	42	40	39	60
Antenatal, Intra-partum and Post-partum care	25	32	101	108
Care during labour and birth	156	152	131	105
Child and family health	48	57	30	50
Community nursing	265	252	270	298
Critical Care	513	575	562	598
Drug and Alcohol	39	33	38	43
Education	57	72	46	45
Emergency	546	621	680	776
Health promotion	23	22	20	19
Management	51	49	61	66
Maternity care	112	129	119	136
Medical	1,932	1,929	2,216	2,307
Mental health	904	804	938	977
Midwifery education	4	np	np	5
Midwifery management	0	np	0	np
Midwifery research	np	np	np	np
Mixed medical/surgical	1,289	1,262	1,382	1,481
Neonatal care	32	26	233	227
Paediatrics	376	411	379	368
Palliative care	107	151	138	138
Peri-operative	794	922	1,030	1,066
Policy	np	np	np	6
Postnatal care	182	169	136	165
Practice nursing	489	515	516	626
Rehabilitation and disability	607	610	716	683
Research	32	28	18	24

Surgical	1,599	1,690	1,840	1,791
Other	514	503	562	555
Not stated/inadequately described	0	np	0	0
Total	**13,880**	**13,915**	**15,607**	**16,138**

Setting of main Job				
Locum private practice	17	14	10	0
General practitioner (GP) practice)	473	492	478	612
Other private practice	266	244	275	162
Aboriginal health service	27	36	30	36
Community health care service	445	411	435	469
Hospital	8,618	8,953	9,979	10,312
Outpatient service	187	199	231	240
Residential health care facility	2,734	2,508	3,062	3,005
Residential mental health care service	0	0	0	0
Hospice	43	37	41	34
Commercial/business service	29	29	38	21
Tertiary educational facility	38	45	44	33
School	15	19	20	15
Other educational facility	19	15	8	5
Correctional service	57	47	43	48
Defence forces	49	64	76	39
Other government department or agency	63	65	55	62
Other	354	309	330	314
Not stated/inadequately described	446	428	452	731
Total	**13,880**	**13,915**	**15,607**	**16,138**

Visa Type				
457 Temporary Work (skilled)	538	213	314	406
485 Temporary graduate	325	334	436	514
Other	170	114	170	226
Not temporary	567	453	553	576
Not reported not stated	12,280	12,801	14,134	14,416
Total	**13,880**	**13,915**	**15,607**	**16,138**

Source: NHWDS Nursing and Midwifery Practitioners, 2013-2017

Not stated/inadequately described includes non-respondents to the survey

For further information on these tables, refer to the 'Notes' sheet

Table 10.2: First year of registration for employed registered nurses by indigenous status, area of nursing, setting of main job and visa type, 2014-17

	2014	2015	2016	2017
Indigenous status				
Indigenous	91	113	116	167
Non-Indigenous	7,988	7,574	9,111	9,604
Not stated	1,537	2,184	1,926	2,006
Total	**9,616**	**9,871**	**11,153**	**11,777**
Area of Nursing				
Aged care	1,531	1,479	1,802	1,959
Antenatal, Intra-partum and Post-partum care	0	0	np	np
Child and family health	43	45	26	41
Community nursing	192	180	195	212
Critical Care	486	544	531	569
Drug and Alcohol	34	27	31	34
Education	42	53	34	38
Emergency	490	553	610	699
Health promotion	18	18	15	16
Management	36	45	52	53
Maternity care	105	112	101	128
Medical	1,447	1,497	1,739	1,780
Mental health	727	637	752	788
Mixed medical/surgical	974	943	1,024	1,142
Neonatal care	0	0	178	190
Paediatrics	346	375	339	341
Palliative care	82	117	108	102
Peri-operative	666	781	901	934
Policy	np	np	np	5
Postnatal care	0	0	0	0
Practice nursing	339	349	333	415
Rehabilitation and disability	408	405	485	479
Research	25	26	15	20
Surgical	1,269	1,328	1,494	1,421
Other	353	355	384	409
Not stated/inadequately described	0	0	0	0
Total	**9,616**	**9,871**	**11,153**	**11,777**

Setting of main Job				
Locum private practice	13	7	9	0
General practitioner (GP) practice)	329	347	317	406
Other private practice	164	147	176	113
Aboriginal health service	17	25	16	21
Community health care service	311	289	305	346
Hospital	6,908	7,222	8,137	8,454
Outpatient service	148	150	184	194
Residential health care facility	1,329	1,296	1,619	1,692
Residential mental health care service	0	0	0	0
Hospice	32	25	27	24
Commercial/business service	20	17	27	15
Tertiary educational facility	34	39	34	31
School	10	17	15	13
Other educational facility	14	9	4	np
Correctional service	54	42	38	41
Defence forces	0	7	6	np
Other government department or agency	41	42	34	45
Other	192	190	204	207
Not stated/inadequately described	0	0	np	171
Total	**9,616**	**9,871**	**11,153**	**11,777**

Visa Type				
485 Temporary graduate	491	190	291	385
457 Temporary Work (skilled)	319	332	436	512
Other	148	99	142	194
Not temporary	489	363	433	498
Not reported not stated	8,169	8,887	9,851	10,188
Total	**9,616**	**9,871**	**11,153**	**11,777**

Source: NHWDS Nursing and Midwifery Practitioners, 2013-2017
Not stated/inadequately described includes non-respondents to the survey
For further information on these tables, refer to the 'Notes' sheet
(Note: Totals in Setting of main Job are inconsistent with other totals)

Table 10.3: First year of registration for employed enrolled nurses by indigenous status, area of nursing, setting of main job and visa type, 2014-17

	2014	2015	2016	2017
Indigenous status				
Indigenous	72	61	93	82
Non-Indigenous	2,534	2,332	2,588	2,625
Not stated	1,227	1,257	1,352	1,202
Total	**3,833**	**3,650**	**4,033**	**3,909**
Area of Nursing				
Aged care	1,614	1,393	1,613	1,467
Child and family health	5	12	4	9
Community nursing	73	72	75	87
Critical Care	27	31	32	29
Drug and Alcohol	5	7	7	9
Education	15	19	12	7
Emergency	56	68	71	77
Health promotion	5	5	5	np
Management	15	4	9	13
Maternity care	7	17	18	8
Medical	485	434	481	527
Mental health	178	169	187	191
Mixed medical/surgical	318	320	358	341
Neonatal care	0	0	18	11
Paediatrics	30	36	40	27
Palliative care	25	34	30	36
Peri-operative	128	143	130	133
Policy	0	0	0	np
Practice nursing	150	167	183	212
Rehabilitation and disability	200	206	232	204
Research	7	np	np	4
Surgical	332	364	350	370
Other	158	145	175	143
Not stated/inadequately described	0	np	0	0
Total	**3,833**	**3,650**	**4,033**	**3,909**

Setting of main Job				
Locum private practice	4	7	np	0
General practitioner (GP) practice)	144	147	161	207
Other private practice	102	99	99	49
Aboriginal health service	10	11	14	15
Community health care service	134	124	131	124
Hospital	1,717	1,739	1,855	1,863
Outpatient service	39	50	47	46
Residential health care facility	1,413	1,229	1,458	1,326
Residential mental health care service	0	0	0	0
Hospice	11	12	14	10
Commercial/business service	9	12	11	6
Tertiary educational facility	4	6	10	np
School	5	np	5	np
Other educational facility	5	6	4	4
Correctional service	np	5	5	7
Defence forces	49	57	70	36
Other government department or agency	22	23	21	18
Other	162	119	127	107
Not stated/inadequately described	0	np	0	87
Total	**3,833**	**3,650**	**4,033**	**3,909**

Visa Type				
457 Temporary Work (skilled)	11	9	11	8
485 Temporary graduate	9	10	5	6
Other	22	17	27	30
Not temporary	65	83	109	64
Not reported not stated	3,726	3,531	3,881	3,801
Total	**3,833**	**3,650**	**4,033**	**3,909**

Source: NHWDS Nursing and Midwifery Practitioners, 2013-2017

Not stated/inadequately described includes non-respondents to the survey

For further information on these tables, refer to the 'Notes' sheet

Table 10.4: First year of registration for employed midwives by indigenous status, area of midwifery, setting of main job and visa type, 2014-17

	2014	2015	2016	2017
Indigenous status				
Indigenous	9	10	12	10
Non-Indigenous	548	502	533	638
Not stated	48	105	71	78
Total	**605**	**617**	**616**	**726**
Area of midwifery				
Antenatal care	57	51	50	77
Care during labour and birth	212	215	169	172
Continuum of midwifery care	42	52	146	169
Maternal and child health	0	0	0	0
Midwifery education	6	5	np	7
Midwifery management	np	np	np	5
Midwifery research	np	np	np	np
Neonatal care	43	36	50	41
Postnatal care	233	236	179	227
Other	8	18	15	26
Not stated/inadequately described	0	0	np	np
Total	**605**	**617**	**616**	**726**

Setting of main Job				
General practitioner (GP) practice)	np	0	np	np
Specialist (O&G) practice	np	np	np	np
Group midwifery practice / caseload	14	np	14	14
Aboriginal health service	np	np	np	np
Community health care service	np	5	np	0
Hospital	544	568	554	640
Outpatient service	21	16	19	40
Tertiary educational facility	9	4	6	7
Other educational facility	np	np	0	0
Other government department or agency	0	0	0	np
Other	4	16	14	18
Not stated/inadequately described	np	0	np	np
Total	**605**	**617**	**616**	**726**

Visa Type				
457 Temporary Work (skilled)	51	16	15	15
485 Temporary graduate	0	0	0	np
Other	np	0	np	5
Not temporary	14	10	12	17
Not reported not stated	539	591	587	686
Total	**605**	**617**	**616**	**726**

Source: NHWDS Nursing and Midwifery Practitioners, 2013-2017
Not stated/inadequately described includes non-respondents to the survey
For further information on these tables, refer to the 'Notes' sheet

NOTES REGARDING NHWDS DATA:

1. Data are extracted from the National Health Workforce Dataset: Nurses and midwives, 2013-17. Note that the 2013 data was required to derive the 2014 numbers (see 2 below).

2. These data are for nurses and midwives that first appeared on the NHWDS database in the reference year (i.e. were not in the NHWDS database in the year prior)

3. The results for new registration are likely to be affected by the timing of graduation, conducting of the survey and recruitment action by significant employers. As a result there are likely to be variations across jurisdictions and years.

4. Any cell containing 3 or less practitioners has been set to ‘np’ (not published) for reasons of confidentiality

5. In order to remain consistent with previous AIHW analyses, Enrolled Nurses/Registered Nurses/ Midwives are defined using division withing the profession, rather than the respective registration flags.

6. In order to remain consistent with previous AIHW analyses, Indigenous Status Grouped has been used to define Indigenous Status, rather than Australian Born Indigenous Status.

7. In order to remain consistent with previous AIHW analyses, Principal areas are defined based on the nursing job area first, then the midwifery job area, rather than the job area the practitioner spends the most number of hours at.

Table 11.1: Number of graduate transition places - public sector

Organisation	State or Territory	Number of positions for 2016	Additional information
Chief Nurse and Midwifery Officers			
NSW Government Health	NSW	2000 positions for nursing and midwifery	Consideration is given to ensure quality patient care and adequate support to graduates
Tasmanian Government Department of Health and Human Services	Tasmania	115 nurses plus an additional 15 public positions with the election commitment. All graduating Tasmanian midwives are offered a position with the Tasmanian Health Service (no number was provided)	
Department of Health and Human Services Victoria	VIC	2093 positions were offered in public and private hospitals in the Computer match process (1929, listed for the public health sector)	Victorian Government do not directly employee graduates. They provide 26m each year to support public sector employers to provide graduate programs
Queensland Government Department of Health	QLD	1900 offers of employment for 2016	Queensland Government has committed to $110.67m for Queensland graduates. Up 4000 places for the next 4 years, plus 16 new nurse educators.
ACT Government Health	ACT	100 Registered Nurse positions 10 Midwifery positions	Assistance would be beneficial for some supernumerary time and facilitation

Note: Table not updated with latest data

APPENDIX 2

National Early Career Nurse and Midwife Roundtable

Employment of newly graduated and early career nurses and midwives

Facts and Myths – Information Sheet

Introduction

In December 2014 the Australian Nursing and Midwifery Federation (ANMF) convened a National Graduate Nurse and Midwife Roundtable with key nursing and midwifery leaders and other relevant stakeholders to discuss and develop solutions to secure improved employment opportunities for early career nurses and midwives.

All participants at the roundtable agreed there was a significant problem of underemployment of newly graduating nurses and midwives, the causes of which are complex and varied. A working group was then established to address a number of key objectives including improving data related to students and registration numbers, research into graduate/transition programs and a document to address the myths that may impede the employment of early career nurses and midwives.

The following document has been developed by the working group of the Roundtable to highlight the facts of undergraduate education and to bust the myths.

FACTS

Undergraduate nursing and midwifery programs

Programs leading to registration for registered nurses, enrolled nurses and midwives with the Nursing and Midwifery Board of Australia are required to meet multiple standards prior to their delivery by approved education providers.

These include:

- Education providers' internal standards and processes
- The standards of the Tertiary Education Quality and Standards Agency
- The Australian Skills Quality Authority standards (Diploma of Nursing)
- Accreditation by the Australian Nursing and Midwifery Accreditation Council.

Overview of program requirements

Registered Nurse

- Minimum Award: Bachelor Degree
- Program length: 3 years full time equivalent
- Minimum clinical hours: 800 hours plus simulation
- Cost to the graduate to complete the course: $20,000 up to $30,000.

Midwife-direct entry:

- Minimum Award: Bachelor Degree
- Program length: 3 years full time equivalent
- Minimum clinical hours: Extensive plus simulation
- Cost to the graduate to complete the course: $20,000 up to $30,000

Midwifery can also be completed as a post graduate diploma if the student is entering as a nurse. The program is 12 months in length.

Enrolled Nurse:

- Minimum Award: Diploma
- Program length: 18 months
- Minimum clinical hours: 400 hours plus simulation
- Cost to the graduate to complete the course: $10,000 up to $20,000

Data relating to early career nurses and midwives

To understand the issue of underemployment of newly graduated nurses and midwives now and into the future, it is essential we have accurate data that details the experience of registered nurses, enrolled nurses and midwives post completion of their undergraduate studies. However, the complete data picture regarding the employment of newly registered nurses, enrolled nurses and midwives is not easy to ascertain.

The Nursing and Midwifery Board of Australia (NMBA), as the national regulator for nurses and midwives, is able to quantify the number of new registrations as a registered nurse, enrolled nurse or midwife who have completed their undergraduate (or post graduate programs of midwifery study which lead to registration as a registered midwife) approved program in Australia. This data is captured when graduates first apply for general registration. The NMBA together with the Australian Health Practitioner Regulation Agency (AHPRA) maintain a register with respect to students in approved nursing and midwifery programs. However, there are current limitations with the student register, and AHPRA and the NMBA plan to improve the linkages between the student and general register data.

State and territory governments also collect data relating to the number of first year registered nurses, enrolled nurses and midwives gaining employment, however, this data is confined to public health settings.

The Commonwealth Government collects data at renewal of registration for nurses and midwives through the annual workforce survey. However, the dataset regarding employment of first time registrants is not definitive for a number of reasons.

Data for midwives is even more difficult to ascertain. In some data sets such as that published by Graduate Careers Australia, midwives are included within the registered nurse data and cannot be separated.

The above examples highlight that existing datasets are incomplete and the quality of the data needs to be improved.

A more accurate picture of the current position for nearly graduating nurses and midwives wanting employment can only be gained by blending the existing data sources together.

Workforce numbers

Evidence predicts that Australia is heading for significant shortages of nurses and midwives within the next two decades with a current replacement rate of 0.9[1]. Considering this shortage, the table below outlines the current data sources relating to graduate employment. The data highlights the increase in students commencing study from 2010 to 2015 and shows a decrease in full time employment for graduates four months after graduation in the same time period.

Type	2010	2011	2012	2013	2014	2015
Course commencements for domestic undergraduate registered nurse students[2]	13,838	13,779	15,290	16,320	17,581	18,950
Nursing University Graduates employed full time 4 months after they graduate[3]	92.9%	92%	92.2%	83.1%	80.5%	79%

With evidence that the professions are heading toward a significant shortage by 2025, increasing the numbers of students commencing programs has been critical. The uncapping of university undergraduate places has facilitated this increase. However, the increase in student numbers in some jurisdictions has not been accounted for within the employment setting, resulting in a disconnect with the number of available early career nursing and midwifery positions and the related employment of new nursing and midwifery graduates.

A compounding factor to the projected shortfall is the evidence suggesting early career nurses and midwives are not being retained within the workforce. Their reasons for leaving the professions are varied, but can relate to high levels of stress and in some contexts unacceptable workloads, lack of support and guidance and too much responsibility[4]. It is essential that maximum effort is exerted to do all we can to ensure early career nurses and midwives are employed and retained within the professions. These nurses and midwives need, firstly, appropriate employment and, secondly, to be respected for what they bring to health or aged care settings.

MYTHS

Whilst many early career nurse and midwives obtain employment and experience a positive transition to practice, some do not. The following myths attempt to bust some inaccuracies in the views of the professions to early career nurses and midwives and the poor cultural attitudes that may confront early career nurses and midwives in their first few years of practice.

Myth 1
Early career nurses and midwives must complete a formal graduate program to be employed

Myth 2
Early career nurses and midwives are not 'work ready'

Myth 3
Dedicated resources are not required to support early career nurse and midwife transition

Myth 4
Unlicensed workers can replace early career nurses and midwives

Deconstructing the myths

Myth: It is mandatory to have done a graduate program (transition to practice, new graduate year, or graduate placement) to be employed as a registered nurse or midwife.

Whilst every early career registered nurse and midwives should be supported to transition from undergraduate student to nurse or midwife, there is no regulatory requirement preventing the early career nurse or midwife from being employed where they have not completed a formal transition to practice program. Newly graduating nurses and midwives need additional support from other registered nurses and midwives as they gain confidence in adapting to their new role and setting.

Myth: Early career nurses and midwives are not 'work ready' in their first year of practice.

The concept of 'work ready' is unhelpful and creates confusion amongst the professions. The expectations of newly registered nurses and midwives must be realistic and be founded upon the understanding that newly graduated registered nurses and midwives have an individual and beginning practitioner's scope of practice. They have completed the professions' agreed education programs leading to registration, which have included extensive theory and practice, and they have been assessed as competent, meeting the relevant standards for practice.

These nurses and midwives have much to offer their clients/patients and the nursing and midwifery professions. Like other nurses and midwives, early career nurses and midwives have experience and skills in some areas of practice and will need support to develop in others.

Early career nurses and midwives are not just 'graduates', they are nurses and midwives with an individual scope of practice. They have earned the right to be respected and supported within their chosen profession. They need acknowledgement and respect for what they bring to their practice. As with all nurses and midwives they also need support to continue to develop their individual scope of practice depending on the context of practice.

Myth: Effective support can be provided to early career nurses and midwives without adequate nursing and midwifery resources and relevant education e.g. preceptor programs or quality transition and support of newly graduating nurses and midwives.

Adequate resourcing and clinical education are required to enable registered nurses and midwives to provide adequate support to early career nurses and midwives as they transition from undergraduate student to a nurse or midwife. Formal transition to practice programs provide a means to ensure resources are provided to support newly graduating nurses and midwives in their transition to practice.

Myth: Employing an unlicensed health worker instead of a newly graduated registered nurse saves money and doesn't make a difference to patient outcomes

It is a false economy to employ an unlicensed health worker instead of an early career registered nurse. Research indicates that patient outcomes are directly affected by staffing skill mix and more specifically, the number of registered nurses and midwives[5 6 7 8]. Registered nurses perform a critical surveillance role in preventing adverse patient outcomes including: the incidence of pressure area sores, patient falls, failure to rescue, urinary tract infections, pneumonia and death. Registered nurses and midwives therefore save money and lives.

Best practice principles for the transition period for newly graduating nurses and midwives

It is important that transition to practice programs occur in a culture of safety. The NMBA Code of Ethics for Nurses in Australia, particularly value statement 6, *Nurses value a culture of safety in nursing and health care*[9] and in the Code of Ethics for Midwives in Australia value statement 6 *Midwives value a culture of safety in midwifery care*[10] advocate for a non punitive systems based approach to human error, development of trusting relationships and an environment in which nurses and midwives see the detection of their own errors as an opportunity for improvement is essential. The following best practice principles identify the importance of a safe environment for early career nurses and midwives as well as a number of other important recommendations. These recommendations were produced through a research project funded by the Nursing and Midwifery Policy Wellbeing, Integrated Care and Ageing Department of Health (2012)[11] and have been adopted by the Graduate Nurse and Midwife Round Table Group. These principles were developed in and for the Victorian context and will need to be adapted when used in another state or territory.

Principles		***Summary***
1	*Learning and development is valued*	*Best practice transition programs are planned learning and professional development experiences that address both early graduate and workplace needs.*
2	*Nurses and midwives and their contribution are valued*	*Best practice transition programs thrive in an organisational culture that values nurses and midwives, their contribution to client care, service delivery and the role of the graduate in the health team.*
3	*A safe and supportive working environment is provided*	*Best practice transition programs are based on the understanding that early graduates are prepared through their tertiary qualifications for beginning level practice.*
4	*Planned experiences that address both graduate and workplace needs are undertaken*	*Best practice transition programs are delivered in organisations that value learning, professional development, evidence based practice and research.*

5	*Experienced professionals…*[support]*, direct and instruct graduates*	*Best practice transition programs are provided in a safe and supportive work environment that complies with the principles of the Occupational Health and Safety Act, 2004.*
6	*A holistic program is provided, incorporating professional, social and broader life issues*	*Best practice transition programs adopt a holistic approach that considers professional, social and whole of life issues.*
7	*The transition program is aligned with quality, safety and risk management policy*	*Best practice transition programs are integrally linked to the organisation's quality, safety and risk management frameworks.*

Glossary

Early Career nurse or midwife: a nurse or midwife who has recently (1-2 years) graduated from a program leading to registration as a nurse or midwife.

Transition/ Graduate program: A structured employment program or period of time that is offered to newly graduating nurses and midwives with the intention of providing support for their transition into employment as a nurse or midwife.

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SENATOR THE HON RICHARD COLBECK
Minister for Aged Care and Senior Australians
Minister for Youth and Sport

Ref No: MC19-012241

20 SEP 2019

Ms Beth Mohle
Secretary
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Dear Ms Mohle

Thank you for your correspondence of 1 August 2019 regarding the urgency motion around the unexpected evacuation of care recipients at the residential aged care facilities located at Earle Haven Retirement Village. I apologise for the delay in responding.

The Australian Government is committed to ensuring the safety and quality of care for older Australians. Commonwealth-funded aged care providers are required by law to meet the Aged Care Quality Standards (Standards) to ensure that quality care and services are provided to consumers. Where they fail to do this, there is a regulatory framework in place to bring them back into compliance as quickly as possible.

In accordance with the new Standards, approved providers of residential aged care must ensure they have a workforce that is sufficient, skilled and qualified to provide safe, respectful and quality care and services. The Standards do not prescribe the qualifications required by staff, or the number of staff required to be employed by an aged care service as this may vary depending on the care needs and profile of care recipients.

The Government's view is that aged care providers are best able to determine their workforce needs and staff skill mixes. This is because the relationship between staffing in aged care homes and the quality of the care provided is complex.

I have commissioned an independent inquiry, led by Ms Kate Carnell, into the events surrounding the unexpected closure of the aged care facilities operated by People Care Pty Ltd in Nerang, Queensland.

This inquiry will examine the circumstances leading to a collapse in the provision of care services for the residents of the facility and the impact and consequences of the event.

It will also look at whether it could have been prevented, along with the management and operational structure of the service and the governance, management and operational structure of People Care and its sub-contractor HelpStreet.

The outcome of this inquiry will assist us to understand why this situation occurred, what we can do to prevent this type of event in the future and that those responsible are held to account. The terms of reference can be located via the Department of Health's website: www.health.gov.au.

Thank you for raising this matter.

Yours sincerely

Richard Colbeck