New Zealand Nurses Organisation

Feedback to the Nursing Advisory Committee on the Clinical Workforce to Support Registered Nurses

August 8, 2008

Inquiries to: Marilyn Head
New Zealand Nurses Organisation
PO Box 2128, Wellington
Phone: 04 499 9533
DDI: 04 494 6372
Email: marilynh@nzno.org.nz

EXECUTIVE SUMMARY

1. The New Zealand Nurses Organisation (NZNO) thanks the Advisory Committee for the opportunity to comment on the draft report (10 July 2008) to the Director General of Health on the Clinical Workforce to Support Registered Nurses.

2. The New Zealand Nurses Organisation (NZNO) is a Te Tiriti o Waitangi based organisation which represents over 41 000 nurses and health workers, including the majority of RNs and second-level nurses and 5000 healthcare Workers (HCWs). NZNO is the professional body of nurses and the leading nursing union in Aotearoa New Zealand.

3. NZNO believes that the most effective and efficient nursing service is one that matches nursing skill to patient need. The context and the complexity of patients will determine the most appropriate skill mix and this will vary from setting to setting. However a clear and unambiguous nursing team inclusive of registered nurses (RNs); second-level nurses with one title and scope with a broad, generic training programme; and unregulated nursing support assistants or healthcare workers(HCWs) will provide the public with safe, quality nursing. NZNO believes that the document could have greater clarity by being explicit about this three tier nursing team.

4. NZNO welcomes this document and its recommendations, which endorses the position we have long advocated: that a broad generic second-level nursing role, educated to level 5 of the New Zealand Qualifications Framework (NZQF), should be the key second-level clinical support for RNs developed in the context of a team approach.

5. More than a decade of poor consultation and decisions has resulted in the unworkable situation of having two titles, two scopes of practice and a single set of competencies for the second-level regulated nursing workforce. This has caused confusion for the public and within the sector. It has undermined the credibility of the second-level nurse and negatively impacted on

recruitment into training programmes and employment settings. Thus the health sector and the public have not been able to maximise the potential of this valuable level of nursing to achieve excellence in patient care.

6. It is disappointing to note, therefore, that the recommendations fall short of encompassing a plan of action within a specified timeframe. NZNO advises that unless the recommendations include a timetabled pathway for their swift implementation and specifically exclude further opportunities for re-litigation, there is a very real risk that there will be no second-level nursing workforce left to develop.

7. We recommend that the report includes a Plan of Action, beginning in October, 2008 that aims to:

    - develop a single generic scope for second-level nursing;
    - ensure that relevant education and training is available from the beginning of the 2010 academic year (or earlier if possible); and
    - to advise and educate employers, nurses, other health professionals and the public as to how second-level nurses may be used most effectively.

8. NZNO has consulted its members in the preparation of this response, in particular NZNO members (Colleges and Sections, Board Members and other healthcare workers) and NZNO staff (Management, Professional Nursing Advisors, Policy Analysts, and Industrial Advisors). We have also consulted with colleagues in the United Kingdom, Australia, Canada and the International Council of Nurses.

9. The feedback from members has been <u>overwhelming</u> and consistent: unanimous support for a single generalist scope of practise for second-level nursing and reinstatement of the widely recognised Enrolled Nurse title.

10. Specific comments and examples inform the detailed discussion below and NZNO urges you to consider that this feedback represents the majority of the

nurses in clinical practice that this report addresses: second-level nurses, both ENs and Nurse Assistants (NAs) mainly educated in New Zealand, but including many who have worked in other countries – and their closest professional colleagues, Registered Nurses (RNs).

11. NZNO believes that a primary cause of the protracted debate over second-level nursing is that inadequate consideration has been given to the voice of nurses in clinical practice. The report reflects a similar bias, most notably by:

    - omitting ENs in the first part of Section 4 describing the current clinical workforce;
    - failing to identify the negative impact that the current confusion over scopes and titles has had on attracting, retaining and properly utilising second-level nurses;
    - not recognising how the 2003 Health Practitioners Competence Assurance Act (HPCAA) in combination with a growing non-regulated workforce has aggravated the current nursing situation; and
    - making no provision for NZNO or any other professional workforce involvement in the tasks associated with Principle 2.

12. NZNO suggests there are some significant factors impacting on the current role and situation of ENs/NAs in the health environment which indicate the continued need for a regulated generalist second-level nursing role and which need further clarification.

13. NZNO strongly contends that to develop and promote "a second-level clinical workforce within the context of a teamwork approach", the team itself needs to be included in the entire process, not merely consulted about the results of the discussions. This is implicit in the 2003 Health Practitioners Competence Assurance Act (HPCAA) whose purpose, that of protecting public health and safety by ensuring that health practitioners are competent and fit to practise, dictates the framework under which clinical roles should be developed.

14. Thus, in line with Section 14 (2), and in view of NZNO's sustained representation of the large majority of second-level nurses, we recommend that NZNO be included in the bodies undertaking the Tasks relating to Principles 2 and 3.

15. NZNO notes that for Maori the EN role has always been an important route into the professional health workforce and that many prominent and influential Maori nurses began as ENs. Feedback from Te Runanga O Aotearoa, the Maori arm through which NZNO's Treaty partnership is expressed, has been equally strong and it is widely held that, had the EN role not been compromised and thus made less appealing, many more Maori ENs would have been available to iwi providers. Instead, Hauora, which are significantly under resourced, have had to rely disproportionately on untrained caregivers, with an inferior capacity for improving health outcomes and an important pathway for Maori participation in the professional health workforce, in which they are already significantly underrepresented, has petered out. That a double blow to Maori health has been sustained when so much effort is being put into reducing health disparities is very disappointing.

16. With reference to aligning qualifications with other developed countries (Principle 3), NZNO suggests that alignment with Australia should be prioritised and take precedence over other developed countries for reasons detailed below.

17. NZNO supports principle 4, the need for employers and public *and the nursing workforce* to be made aware of workforce initiatives and new career pathways and agree that leadership and funding for transition pathways for current second-level nurses needs to be provided by Ministry of Health.

DISCUSSION

18. NZNO believes that discussion about the development of clinical roles should take place within the context of the relevant legislative framework, the HPCAA. We endorse the purpose of the HPCAA (2003), to protect public

safety, and suggest that report should be explicit about the impact of the Act within the current health environment, and especially its implications for the nursing workforce.

19. Without the HPCAA perspective, subsequent discussion and reference to non-regulated health workers, the plethora of job titles, employer and public confusion, training and employment opportunities etc., is inadequate and does not convey the complexity of issues relating to the nursing workforce. For example, regardless of whether a non-regulated health worker is trained or capable, only regulated nurses are professionally accountable; for RNs that includes being accountable for the work of HCWs whose work they direct and delegate. Thus the rise in the number of non-regulated health workers is a concern not only because of quality of care issues, but also because of the heightened risk to RNs who are increasingly responsible for more unregulated workers who may or may not have had any training.

20. Similarly, the low level of understanding of the HPCAA, particularly relating to the employers' responsibilities, as well as the confusion around scopes of practice for second-level nurses, has led to some worrying employment decisions being made for regulated and non regulated workers, many of which have been detailed in NZNO's submission on the HPCAA Review earlier this year. These include situations where:

    - regulated trained nurses have been prevented from working in healthcare roles which unregulated untrained workers have undertaken;
    - employers have opted for unregulated workers who are not restricted by narrow scopes of practice; and where
    - competent highly experienced ENs have been stopped from continuing tasks suddenly deemed out of scope.

21. These are significant, preventable, factors which have impacted heavily on the nursing workforce and are highly relevant to the development of

appropriate clinical roles which will lead to meaningful and satisfactory employment and a more sustainable workforce.

22. In the same vein, while the report refers to the increased healthcare requirements anticipated with an aging population, it does not mention the current lack of mandatory regulation for safe staffing in the Aged Care sector and how that has impacted on recruitment and retention of regulated nurses. RNs will not risk their practising certificates, or the quality of the care they can provide patients, in unsafe environments. Nor is it likely that people will choose to be educated or train as a Nurse Assistant with a specialised focus in Aged Care, if the scope of practice will forever restrict them to employment in that particular healthcare setting.

Section 1: Introduction

23. While nursing shortages are a global problem, the policy regarding second-level nursing has varied considerably from country to country and it would be instructive to point this out, rather than intimating that the situation in Aotearoa is not unique but rather part of a worldwide trend. For example, the United Kingdom abandoned second-level nursing, regulating graduate nurses only. Over time the small unregulated workforce has expanded haphazardly to fill the vacuum with the result that unregulated HCWs now comprise "a substantial proportion of 'hands-on' patient care working in a variety of clinical areas" (Storey, 2007). That situation has provoked widespread concern for public safety, quite outside of the context of nursing shortages as was recognised in the UK Government's White Paper *Trust, Assurance and Safety – The Regulation of Health Professionals in the 21st Century* (February 2007). Conversely, Australia has strengthened the position of ENs in the healthcare environment with strong policy directives which ensure ongoing educational and employment opportunities. In such a climate where their role is valued and supported, the number of ENs has not declined as it has in New Zealand. Here, contentious regulatory

changes have led to two separate titles and conflicting scopes of practice for second-level nurses. By focusing on general nursing shortages rather than specific policy outcomes, the report obscures both the particular situation in New Zealand and policy opportunities which may lead to more positive outcomes. The "low uptake of new programmes since 2000, with lower enrolments than anticipated" should not be attributed to general nursing shortages, especially when enrolments for RN courses have not shown the same decline, but rather must be recognised as the direct result of poor workforce regulation and management.

24. NZNO is concerned that the issues relating to non-regulated health workers, which are many and complex, are inappropriately lumped together with issues concerning the regulation of second-level nursing. We believe that they raise quite different "concerns related to the quality of clinical support available to the registered nurse" and that the report needs to clarify the distinctions. We note that in the UK where second-level nursing has been disestablished, that there is now a strong call for regulating healthcare assistants (HCWs) and that Scotland is currently piloting a system of employer-led regulation for healthcare support workers. However, regulation of HCWs is not the issue in New Zealand where we have both an unregulated workforce and a regulated second-level nursing workforce. The discussion needs to be focussed on what differentiates the support that can be safely provided by unregulated HCWs and the support that requires a regulated health practitioner.

Section 2: Factors that influence the health workforce

25. We suggest modifying Section 2.2 Labour Market Forces to read "The registered nursing and second-level clinical workforce *is affected by"* (rather than *is a product of*) and replace *health service requirements* with employment *opportunities*. The former is covered by government policy and

market forces, and the latter recognises the wide range of career choices available to the traditional source of the nursing workforce, young women.

26. Nursing is a physically and mentally demanding job, still largely female dominated and not particularly well remunerated. Good employment conditions, opportunity for training and retraining, workplace flexibility etc. are all proven factors in attracting and retaining staff and should be acknowledged. In the bulleted points we suggest that:

- "workforce migration" would cover both emigration and immigration;
- changing "the type of" to "the flexibility of" education *and career pathways*; and
- adding "employment opportunities and conditions – including pay and employment equity, work/life balance*".*

Section 3. Current workforce initiatives

27. The Ministry of Health's 2006 Raranga Tupuake Maori Health Workforce Development Plan to build a competent, capable, skilled and experienced Māori Health and Disability workforce over the next 10 to 15 years should be included in the list of workforce initiatives.

Section 4. Current clinical workforce to support RNs in New Zealand

28. NZNO notes that ENs are not mentioned in the introduction to this section, even in the sentence defining regulated nurses which currently states that "Registered nurses and nurse assistants are regulated by the Nursing Council." This omission was pointed out by several NZNO members and aptly illustrates why over 3000 ENs continue to feel marginalised and devalued! ENs are currently not being trained in Aotearoa, though they have access to continuing education through District Health Board Professional Development and Recognition Programmes, yet the average

EN will be in the workforce for another twenty years or so. Since they comprise 12 percent of the nursing population, with nursing comprising the largest proportion of regulated healthcare workers, surely it is important to note the training they have had, their level of skill and role in the current clinical workforce? Indeed it is the distinction between the two scopes, not their shared competencies that has been a major bone of contention.

29. In the light of increasing recruitment from overseas, it may also be pertinent to consider the pool of nurses in Aotearoa, including ENs, whose skills for various reasons are not being utilised. Australian-trained members of NZNO who are ENs, have been particularly outspoken about the contrast between their work experiences here and in Australia.

30. The last bullet point in Section 4.1 describes most nurses as European – *New Zealand European* is the term most widely used.

31. 4.2 Second-level nurses. This section does not accurately reflect the debate around second-level nursing. NZNO is concerned that the breadth and rigour of its successive submissions on the content, scope and title for second-level nursing, has been reduced to a '*divided opinion'* over the *title* of enrolled nurse. That is inaccurate and offensive. It does not clarify the contentious situation which prompted convening this Nursing Advisory Committee: that demonstrably poor consultation and unworkable regulation by Nursing Council and non-existent management/leadership by the Ministry have compromised the integrity of the second-level clinical nursing role. Worse, it disregards the effect that that has had on the personal careers and lives of thousands of ENs. Two years ago Judge Broadmore in his conclusion to an NA Appeal against NCNZ taken to the District Court in September 2006 was moved to express his "considerable sympathy" for NA concerns centred around issues concerning their scope of practise and title, and though the appeal failed on technical grounds said"my views are such that I do not consider it appropriate to award costs to the Council". Such

events are highly pertinent. NZNO strongly suggests that the report include a full and accurate summary of the events and decisions which have escalated this situation and would be happy to provide a draft. It is not acceptable that years of serious professional engagement on issues which have profound implications for the nursing workforce and the quality of patient care should be trivialised in such a manner.

32. It is also deeply cynical to imply NZNO was merely one of several "professional bodies" (the others are not named) making submissions relating to the second-level nursing workforce, when NZNO was the professional body representing that workforce and when its membership exceeds comparable organisations by many orders of magnitude. The majority of discrete submissions may have favoured an alternate title and scope, but the overwhelming majority of the nursing workforce did not - a fact that remains unacknowledged in this review.

33. It is similarly misleading to describe Nursing Council's consultations and decisions without revealing the widespread confusion, disruption and hostility they have engendered (Judge Broadmore, 2007) and that the Regulations Review Committee (2007) found their processes to be flawed – a point repeatedly made by NZNO (Annals, 2007).

34. The connection between regulation for a new title and scope for second-level nursing which has resulted in the low uptake of NA training and the limitations on the settings in which they can work, needs to be drawn. NZNO notes, for example, that it was very apparent at Christchurch Polytech that numbers enrolling into the second-level programme were significantly reduced when the title of the graduate was changed to that of Nurse Assistant.

35. A shortage of funded positions is not the only reason that ENs/NAs are unable to gain employment. Employer confusion around their scopes of practice under the HPCAA has drastically affected their employment

opportunities. An example is Capital and Coast DHB's (CCDHB) decision not to employ ENs on night duty, following a decision made by the Health and Disability Commissioner (Health and Disability Commission, 2007). The subsequent replacement of highly experienced ENs with untrained HCWs based on a misinterpretation of that decision, is patently unsound, and illustrates the bizarre outcomes that have arisen because of the uncertainty surrounding employer responsibility for the competence of HPs under the Act. Conflicting advice from the NCNZ and Ministry of Health regarding ENs scope of practice contributed to the confusion causing instability and undermining public confidence.

36. The purpose of regulation (the HPCAA) is to decrease risk and improve quality in the public health sector; dual scopes for second-level nursing do not achieve this. NZNO suggests that consideration should have been given to regulation for safe staffing of both regulated and unregulated carers, according to the seven key elements identified in the Report of the Safe Staffing/Healthy Workplaces Committee of Inquiry (2006).

37. NZNO suggests that "previously trained enrolled nurses and many nurse assistants are limited in the settings in which they can work" be modified to read NAs and some previously trained ENs are limited in the settings in which they can work "which more accurately conveys the generalist scope of the EN in comparison to the currently specialised focus of the NA.

5. Key Issues Identified by the Advisory Committee

38. *5.1 Issues related to the RN*: NZNO agrees that a major issue of the nursing workforce is the shortage of RNs.

39. NZNO members in primary healthcare and rural settings have commented that many RNs undertake tasks entirely suitable for a second-level nurse so the shortage of ENs/NAs impacts on the level at which RNs can practise. The efficient and effective use of our sometimes scarce nursing resources needs to be capably regulated and managed.

40. NZNO notes that Nursing Council's recently published *Guideline: Direction and Delegation* (June, 2008) has clarified the situation of direction and delegation of care to enrolled nurses, nurse assistants and, importantly, direction and delegation of care to unregulated health care workers.

41. We suggest the last paragraph of section 5.1 include reference either to a 'generalist' scope or nursing in a variety of settings.

6. Other countries

42. We suggest that Australia has done more than simply decide to retain ENs – they have actively strengthened the role and provided educational and employment opportunities.

43. We believe that the report should note the Trans Tasman Mutual Recognition Agreement under which Aotearoa and Australia are bound to recognise each others nursing qualifications, and that Enrolled Nurse has been retained as the second-level nursing title in Australia.

44. These factors and the close physical, cultural, and economic connection we have with Australia are hugely significant. Progressive moves towards shared standards and regulation will inevitably lead to greater workforce

integration and it is common sense, especially in terms of public safety in healthcare, to preferentially align our clinical nursing roles with those of Australia, especially where they have proven so effective.

7. Options for clinical support for RNs in NZ

45. NZNO agrees that the problem is complex and that neither the current EN or NA scopes offer a satisfactory solution. We strongly support the development of a newly-defined regulated second-level nursing role. NZNO suggests that a good starting point would be the Australian EN model.

46. References to "second-level clinical support at the non-regulated health worker level" are somewhat confusing. Though the report notes that there are care settings where non-regulated workers "currently work at the second-level under the RN", we believe that this contravenes the HPCAA and that there should be a clear distinction between regulated and non-regulated roles. The burden of responsibility is far greater for a regulated worker with past experience showing that employers have often chosen to employ a non-regulated worker who is not constrained by a particular scope of practice or adherence to a particular code of ethics. Regulated workers are generally paid more in recognition of their education or qualification. If operating at the same level, (yet with differing levels of education and understandings of good nursing practice), it is likely that non-regulated workers would be preferentially employed because they cost less (which would contravene equal pay legislation). The incentive to qualify would also be reduced if regulated workers who may be carrying an additional burden of student debt are less likely to get employment.

47. However, we strongly support flexible cross-creditable training, recognition of prior learning and alternative career pathways within a framework which is consistent with the HPCAA and NZQF.

48. NZNO suggests that it is important to find ways to support the current second-level nursing workforce immediately, to ensure that there is a solid foundation of skilled and experienced nurses on which to build the newly-developed role. Such strategies as funding back-to-nursing education programmes, and nurses entry to practice positions have proved effective elsewhere.

49. NZNO also draws your attention to comments from Te Runanga O Aotearoa relating to the Maori nursing workforce. They note that RN's are vital to the health workforce and that serious consideration needs to be given to recruitment of young and older Maori. The cost of training is a significant barrier and both scholarships and apprenticeship type training are recommended to address this.

50. Second-level nursing is a stepping stone opportunity for those who are impacted upon by structural social inequity, including many Maori. Many senior Maori registered nurses report that they started off as enrolled nurses. ENs comprise a necessary part of the nursing team, demonstrate an impressive skill mix and have a complementary role to RNs and caregivers. Their role has been seriously marginalised by NCNZ and, consequently, by a significant number of employers. Te Runanga strongly supports one second-level generalist nursing workforce with one scope and one title – enrolled nurse.

51. Caregivers/HCWs also have a complementary role and this is another avenue for entry into the nursing workforce which Maori have used. Caregiver roles expose whanau to nursing with the potential to study and train towards regulated roles.

52. These three roles, RN, EN and HCW, offer the opportunity to develop and maintain a solid nursing workforce that sees a collaborative team approach and has potential to build capacity in a realistic and encouraging way. It is particularly important for Maori as it allows many levels of entry into the

nursing workforce and creates a pathway that can be travelled as it fits the individual and the whanau.

8. Recommendations

53. **Principle 1**: NZNO agrees with this principle and the integration of the Enrolled Nurse and Nurse Assistant Scope of Practice into one broad, generic Scope of Practice for second-level nursing at NZQA level 5 that is aligned with equivalent developed countries.

54. NZNO strongly recommends, on the basis that it is the preference of the overwhelming majority of the second-level nursing workforce and NZNO, which represents the overwhelming majority of nurses, that the title Enrolled Nurse be accepted forthwith. This is line with Australia, the country most closely connected to Aotearoa and which has a vibrant and effective second-level workforce. NZNO strongly recommends that there is a stated preference for alignment with Australia for the development and title of this role.

55. NZNO suggests that the revised generic scope will need to be considerably broader than the current restricted specialty programme for NAs and that the wording needs to reflect this intention. We suggest adding “in all settings” to the bullet point “covers the full range of community/client needs”. Provision must be made for current ENs/NAs to re-engage in education programmes to align them with the new second-level nursing role and the planning needs to occur now.

56. NZNO believes that this key change and recognition of the value of the second-level nurse within the regulatory framework of NCNZ is urgently required as a matter of public safety in New Zealand.

57. NZNO agrees that Ministry of Health and DHB’s should collaborate to analyse the expected demand within the wider health sector for the second-level nurse, but suggests that the words “and plan for” be added, to ensure

action follows. The move towards maintaining older people in their home environment for instance, provides opportunities for second-level nurses in community care. Similarly, the corollary - that people going to Rest Homes and long-term residential and hospital care are more acutely unwell than formerly – requires provision for the full complement of nursing and patient care in these settings: RNs, ENs/NAs and HCWs working together.

58. NZNO agrees that that DHB's should be promoting the employment of Enrolled Nurse positions and notes that there is a Memorandum of Understanding to this effect in the District Health Boards/NZNO Nursing and Midwifery Multi Employer Collective Agreement. The lack of opportunity in the current environment has contributed to the shrinking second-level nursing workforce. We suggest that marketing and recruitment strategies, including return to nursing opportunities, and the provision of re-orientation programmes would be useful ways of signalling that second-level nursing was valued and was a realistic career option.

59. We strongly recommend avoiding further delay by using the Australian framework as an immediate starting point for a full second-level nursing education programme.

60. **Principle 2.** NZNO agrees with this principle of promoting second-level nursing within the context of a teamwork approach to the delivery of care. We suggest adding the word "regulated" to emphasise the distinction of this role from that of HCWs, though RNs are responsible for the delegation and direction of both. We note that lack of clarity regarding this distinction has been exacerbated by the Nurse Assistant title, where it is widely assumed that "Assistant" equates to HCW, particularly as HCWs are often referred to as Healthcare Assistants. Advertisements for "Nurse's Assistants" are not uncommon and demonstrate the lack of recognition of NA as the title of a regulated scope.

61. NZNO does **not** agree with some aspects of the Tasks and is extremely disappointed to note that no consideration has been given to including the workforce itself in the development of the role. Good practice, commonsense and equity would indicate that the nursing workforce must be involved in something which will impact in such a substantive way on the livelihood of nurses and the effectiveness of the health system as a whole. NZNO is not confident that proper consultation processes, such as those outlined in the State Services Commission guidelines, are well understood and subscribed to. Nor are we sanguine that the mix of Ministry of Health, NCNZ and Careerforce is sufficiently balanced from a workforce perspective, i.e. access to and understanding of present day to day workforce interaction across the spectrum of healthcare in a variety of settings. NZNO believes that poor decision-making which has led to the current unworkable and unsafe regulation and which has effectively disenfranchised an echelon of valued and skilled nurses, is a direct consequence of disregarding the considered views of the majority of the workforce.

62. We strongly recommend that representative workforce organisation involvement be specified in the development of this role and suggest that NZNO, as the leading advocate for second-level nurses, would be the most appropriate choice. We note that workforce participation is considered integral to improving quality of care and productivity as evidenced by clauses in the MECAs and Health Sector Relationship Agreement affirmed by the Government/Ministry of Health, all DHBs and the NZCTU Health sector unions.

63. **Principle 3.** NZNO agrees that an education pathway should be developed for the regulated second-level nurse and the non-regulated health workforce and provide an achievable staircase to a Registered Nursing qualification with exit and re-entry points. We are confident that this is achievable and

again urge NZNO participation to ensure effective, safe and workable solutions.

64. We welcome the recognition of prior learning and achieved competencies which are consistent throughout New Zealand. We suggest inserting the word “standardised” in front of “education programmes” to emphasise the importance of uniformity of education provision, which is currently lacking.

65. NZNO suggests that alignment with “the developed countries” is too generalised a statement to be meaningful and suggests the phrase is replaced with alignment with Australia for reasons previously mentioned.

66. We note that the title Enrolled Nurse is the most widely accepted title for second-level nurses, particularly in the Asia Pacific region.

67. **Principle 4:** NZNO agrees with this principle and recognises that change management will be challenging, especially in some Tertiary Institutions. We strongly suggest that the national campaign is developed and implemented quickly and believe that the recognition and promotion of second-level nursing will have several benefits besides retention and recruitment, most significantly in validating ENs and clarifying the valued place and significant contribution they make to health system.

68. We suggest that funding for new graduate programmes for the second-level nursing workforce in DHB’s would help alleviate some of the nursing workforce vacancies there and provide the second-level nurse with better clinical experience. Such a programme could be developed along the same lines as the Registered Nurse New Graduate programme in DHB’s.

69. We strongly recommend that a Plan of Action within a specified short timeframe is included. NZNO does not believe the Committee, the Ministry or the Nursing Council fully recognises the degree of frustration, anger and hostility among ENs and their RN colleagues who rely on and value their skill and support, over this issue.

CONCLUSION

70. In conclusion NZNO once more thanks the Committee for this opportunity to comment on the draft report, which we trust will lead to a positive resolution. However, we do not feel confident about the latter because the report lacks the urgency which a more thorough analysis of the cause and effect of decisions about second-level nursing would reveal. From the original decision to cease EN training in 1993 to NCNZ's persistence with dual scopes and the Ministry of Health's confused direction, the critical second-level clinical nursing role has been undermined and compromised, to the detriment of public health and safety and the nurses themselves. Through that entire period, the nursing workforce has sent a strong and consistent message, which has just as consistently been ignored. This report continues that trend. It describes NCNZ surveys and "consultations" but doesn't describe what has happened as a result of its decisions. Nor does it explain how confusion around the second-level nursing role took on a new significance with regulation under the HPCAA which has led to some significantly silly, inconsistent and unsafe decisions about what second-level nurses can and cannot do.

71. A demoralised, shrinking second level nursing workforce, public and employer confusion, failure to attract recruits, poor utilisation of skills and a lowered incentive for Maori to join the regulated health workforce are not consequences that can be attributed to global workforce shortages. They are the consequence of specific policy and regulatory decisions and need to be recognised as such so that they can be addressed with the requisite urgency. The extraordinary member response to this report, with RNs, ENs and NAs detailing the professional diminishment, employment losses, costs and time in pursuing education opportunities and professional mismanagement experiences resulting from this protracted debate are a sobering reminder that real lives are being affected. The message the report should send to the Director General of Health is that there is a state

of crisis with second-level nursing that the Ministry of Health must take a leadership role in addressing.

72. NZNO believes the report should recommend that: the Ministry of Health lead a programme to establish a single generic second-level nursing role with the Enrolled Nurse title, based on and aligned as closely as possible with the Australian EN scope; that NZNO as representative of the majority of the every level of the nursing workforce, be a key participant; that education for both new recruits and current EN/NAs be available by 2010; and that a national campaign to promote the new EN role be developed.

Marilyn Head
NZ Nurses Organisation

References

Annals, G. (2007). Debunking the myth of unsafe enrolled nurse practice. *Kai Tiaki Nursing New Zealand.* 13, 5. P. 29.

District Court at Wellington (15 February, 2007). *Judgement of Judge T.J. Broadmore.* Wellington

Health and Disability Commission. 2007. *A Report by the Health and Disability Commissioner: Case 05HDC11908.* HDC pp19-21

Regulations Review Committee (May 2007). *Complaint regarding notice of scopes of practice and related qualification prescribed by the Nursing council of New Zealand.* Wellington

Safe Staffiing/Healthy Workplaces Committee of Inquiry. 2006. *Report of the Safe Staffing/Healthy Workplaces Committee of Inquiry* retrieved January 2007 from
http://www.nzno.org.nz/Site/Campaigns/safestaffing.aspx

Storey, Lee. 2007. Regulation of healthcare assistants: an ongoing debate, *British Journal of Healthcare Assistants*. Vol 1, Issue 1.

ABOUT THE NEW ZEALAND NURSES ORGANISATION

73. The New Zealand Nurses Organisation (NZNO) is a Te Tiriti o Waitangi based organisation which represents over 41 000 nurses and health workers. NZNO is the professional body of nurses and the leading nursing union in Aotearoa New Zealand. Our members include nurses, midwives, students, health care workers and other health professionals.

74. The NZNO vision is “Freed to care, Proud to nurse”. Our members enhance the health and wellbeing of all people of Aotearoa New Zealand through ethically based partnerships. Our members are united in the achievement of their professional and industrial aspirations.

75. NZNO has consulted its members in the preparation of this submission in particular NZNO staff (Management, Professional Nursing Advisors, Policy Analysts, and Industrial Advisors) and NZNO members (Colleges and Sections, Board Members) and other health care workers.